Ontario

April 1984

Survey of behaviour training programs

Prepared for the
Ministry of Community and Social Services
by Doherty Social Planning Ltd.

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Ontario

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April, 1984

Dear Readers:

We are pleased to present to you this survey of community based behaviour training programs for persons with developmental handicaps in Ontario, funded by the Ministry of Community and Social Services. The report provides a descriptive overview of the programs including clients served, program content, lessons from experience and developments of particular interest for future service development.

Since 1974, the Ministry of Community and Social Services has been funding a variety of community services for individuals with developmental handicaps and their families. The emphasis has been on the creation and expansion of a range of services to enable children and adults with developmental handicaps to live in the community and to reduce the need for placements within institutions.

Recently, the Ministry has been documenting the experiences from the growth of different types of community support programs for persons with developmental handicaps, including family support, infant development, behaviour training and communication programs. The reports are a means of sharing with the service community, information that can contribute to learning from each other's experiences, self-evaluation, and the quality of services provided.

The information obtained from the surveys and studies will also contribute to the Ministry's review of whether various activities and approaches are consistent with the Minsitry's objectives, what steps could be taken to enhance the effectiveness and efficiency of the programs and what changes would increase the flexibility of the programs to respond to various needs of their clients.

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We think that this particular survey of behaviour training programs will be of interest to a wide range of service providers that provide services to clients in their own homes, residences or other natural settings, and in particular to clients with behaviour exceptionalities.

Yours very truly,

John Burkus

SURVEY OF BEHAVIOUR TRAINING PROGRAMS FOR PERSONS WITH DEVELOPMENTAL HANDICAPS

PREPARED FOR THE ONTARIO
MINISTRY OF COMMUNITY AND SOCIAL SERVICES
BY DOHERTY SOCIAL PLANNING LTD.

APRIL 1984

TABLE OF CONTENTS

	Page
EXECUTIVE SUMMARY	i
CHAPTER I - INTRODUCTION	
History of the behaviour training programs	1
Methodology of the present study	2
Note on statistical information	3
CHAPTER II - PROGRAM DESCRIPTION	
Introduction	4
Sponsorship	4
Advisory Committees	7
Length of program operation	8
Size	8
Perception of mandate	9
Frequency of service	10
Duration of service	11
CHAPTER III - SERVICE DELIVERY CHARACTERISTICS	
Introduction	12
Admission criteria	12
Selection and intake procedures	13
Case termination criteria	14
Drop-outs	15
Readmissions	16
Case documentation	16
Follow-up	18

	Page
CHAPTER IV - PROGRAMMING CONTENT	
Introduction	19
Client goals	19
Mediator goals	20
Major modes of service delivery	20
Major location of service delivery	25
Training packages	25
Monitoring procedures	26
CHAPTER V - STAFFING PATTERNS	
Staff hiring criteria	28
Staff turnover	29
Staff activities	29
Staff training needs	31
Use of consultants	32
Use of volunteers	33
CHAPTER VI - PERCEIVED PROGRAM STRENGTHS AND AREAS OF CONCERN	
Program strengths	35
Program concerns	36
Unserved client groups	37
Services for discharged clients	38
Provision of case management services	38
Community relationships	39

Page

CHAPTER VII - PROGRAM EVALUATION

Introduction 41

Program effectiveness 41

Program efficiency 42

Program research 42

CHAPTER VIII - LESSONS FROM EXPERIENCE

Strengths and weaknesses of the mediator model 43

Learning theory is not always sufficient 45

Mediator data collection 48

Mediators who work for other organizations 48

Developmentally handicapped parents as mediators 51

Language and culture of the family 52

Experience with specific goals 52

Establishing a new behaviour management program 55

CHAPTER IX - DEVELOPMENTS OF PARTICULAR INTEREST

Introduction 57

Staffing through the use of paraprofessionals 57

The client as his own mediator 57

Development of standards and guidelines 58

Peer review system 58

CHAPTER X - FUTURE DEVELOPMENTS 59

GLOSSARY

BIBLIOGRAPHY

APPENDICES

A. The Ministry's initial guideline statement.

B. Respondents (and list of programs).

C. Questionnaire.

D. Sample of a medical information form.

E. Sample of a mediator satisfaction questionnaire.

F. Definitions used by one program for analysis of staff activities.

G. Sample of a form used by staff to record use of time.

H. Guidelines for peer review.

EXECUTIVE SUMMARY

Twenty-five behaviour training programs for the developmentally handicapped, funded under the Developmental Services Act, are reviewed using data obtained from a combination of questionnaire responses and staff interviews.

The programs are operated under a variety of auspices with both advantages and disadvantages being identified as associated with each type of sponsor. Most programs are small and have less than ten staff members. Case loads range from 11 - 130 cases, for a total of over 850 clients receiving treatment at the time of the survey. The major perceived mandates are:

- to train the mediator to be a change agent;
- to maintain the client in the community;
- to lessen the client's maladaptive behaviours; and
- to provide consultation to other agencies.

While officially clients are people who meet the definition of developmentally handicapped, as delineated in the Act, over half the programs reported being asked to serve other client groups, for example, individuals who had sustained brain damage in adulthood. Many programs also find that their staff become involved in the provision of case management services for their clients.

The mediator model is the most frequently used mode of service delivery. Service is usually provided for clients in their place of residence and/or work. The most frequently addressed client goals, for both children and adults, are:

- decrease in non-compliance;
- decrease in aggression; and
- development of self-care skills.

These goals are also those with which programs report having the most success. Less success is reported in reducing stereotyped or self-injurious behaviours.

A wide variety of commercial training materials are used, but many programs also reported relying exclusively on materials they had developed themselves. Client progress is usually monitored through analysis of data, such as behaviour frequency counts, supplemented by direct staff observation.

There appears to be a range of staffing patterns. Most programs reported that when hiring staff they put more emphasis on previous experience and personal qualities, such as ability to work independently, than on academic qualifications. Staff turnover is generally low and workers appear to find the job satisfying. However, because techniques in behaviour management are changing rapidly, it is essential that workers remain up-to-date with new developments. Respondents reported that the size of their staff training budgets makes this difficult to do. There was also a frequently identified need for staff training in family dynamics.

Only one program does not have the services of a consultant or staff psychologist. Some other programs have access to other types of consultation, such as physiotherapy, but most do not. Many respondents expressed the need for social work consultation. There is little use of volunteers. The main reason given by programs for not using volunteers is lack of staff time to provide adequate training and supervision for them.

The major lessons from experience appear to be:

- the mediator model, as practiced by the programs, has many strengths but, for 20-25% of situations, it is not appropriate;

- the behavioural approach has definite advantages, for example, through its provision of specific techniques. However, some mediators need a different approach; or a combination of the behavioural and another approach; for example, counselling to develop insight;

- developmentally handicapped mediators can be taught to implement programs, but they often have difficulty generalizing principles;

- use of staff from another organization, or members of families from another culture, to be mediators raises special issues which must be addressed by the therapist when initiating contact; and

- it is essential to be realistic about what the mediator can do and flexible in the approach used to implement a program.

As a group, the behaviour training programs tend to feel isolated. Most, therefore, identifed a need to develop closer links with each other for information sharing and support. There is also a perceived need for standards and guidelines which would be specific to community-based programs.

CHAPTER I - INTRODUCTION

History of the behaviour training programs

Until the mid 1960's most services to developmentally handicapped people were provided within institutions (Williston, 1971). However, in 1965, the Honourable Matthew Dymond, Minister of Health, announced his intention to reduce the rate of institutionalization by encouraging community care (Dymond, 1965). The Mental Retardation Services Branch was established in 1966 to implement this new provincial goal.

The next step, specific articulation of a policy that services should be provided in a community setting, if at all possible, in preference to an institution, was not taken for another eight years (Welch, 1973). In 1975 the Ministry of Community and Social Services, which had assumed responsibility for the developmentally handicapped the previous year, issued a detailed implementation plan for the development of community services (Ministry of Community and Social Services, 1975). Included in this plan was the concept of community-based training programs which would assist developmentally handicapped people overcome behavioural deficits so that they could remain in the community.

In 1976, funding was provided for a number of pilot projects in behaviour training for the developmentally handicapped. These were to be part of a spectrum of community support services, which included programs such as infant stimulation and Adult Protective Service Workers.

As outlined in the original 1977 guideline statement, (see Appendix A), the behaviour training programs were:

- to use operant conditioning procedures[1] to assist developmentally handicapped people to overcome behaviour problems and learn socially acceptable and adaptive behaviour;
- to operate primarily in the client's natural environment; and
- to use a mediator model; that is, the training of someone in the client's natural environment to implement a treatement program. The staff of the behaviour training services were to act as mediator trainers but not to provide direct service to the client.

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[1] Defined as the encouragement of desired behaviour through application of consistent consequences. This is often known as behaviour modification.

There appear to be two main assumptions which underlie the use of a combination of operant conditioning and the mediator model. These are:

- behaviour is learned by the individual in his natural environment and can be best un-learned and replaced by another behaviour by modifying that environment; and

- primary social agents within the natural environment, such as parents or residence staff, are in the best position to modify that environment.

If the above assumptions are accepted, it would appear to be more effective to try to change behaviour by teaching social agents to use operant conditioning in the client's natural environment, than to use office-based therapy provided by professional staff.

Although the original behaviour training programs were intended to be pilot projects they have actually evolved into on-going operations; some of which have been functioning for seven or eight years. Furthermore, other behaviour training programs have been established in addition to the original group, with the most recent being funded in early 1983. There are now 24(1) programs across the province (see Appendix B). In July, 1983 the Ministry of Community and Social Services commissioned the present study to collect data on the experience of the various programs. The intention was to obtain program information which would be useful not only to existing agencies in their provision of service but also to the Ministry for future planning.

Methodology of the present study

In July, 1983 a workshop was held in Toronto involving eight representatives from behaviour training programs across the province and four Ministry Program Supervisors. The purpose was to provide an opportunity for a cross-section of frontline service providers and Ministry field staff to identify the key issues that they felt should be examined in the study. The following are some of the major issues identified through that process:

- the appropriateness and success of the "pure" mediator model;

- desirable staff qualifications;

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(1) Trent University runs two parallel programs, one for children and the other for adults. If these were counted as two separate programs under one auspices, there would be 25 programs.

- techniques that work or don't work and why; and

- what is realistic to expect parents to be able to do.

A questionnaire (see Appendix C) was developed on the basis of the workshop discussions and mailed to each program in the province. Follow-up was done in one of two ways:

- ten programs (42%) were selected for on-site visits[1] on the basis that the group provided a range of geographic locations and sponsoring organizations. In these situations the questionnaire was completed with agency staff during the visit. This enabled elaboration of responses as desired; and

- the remaining programs were asked to return the completed questionnaire then were phoned at a pre-arranged time so that the researcher could probe for more detail in regard to certain responses if necessary.

In addition to allowing an opportunity for clarification or elaboration of agency responses, the above method gave agency staff an opportunity for additional input.

Note on statistical information

In conducting the study the Ministry wished to be as unobtrusive as possible. Therefore, no expectations were placed on agencies to do an actual file search or client count to answer questions. While some agencies obviously did submit exact data, it became apparent during discussions that others had produced estimates only. Furthermore, the quantitative information was submitted by some respondents as numbers and by others as percentages. Since, in a few cases, it was impossible to convert the percentages back to numbers, all the numbers had to be converted into percentages in order to make comparisons.

In light of the above, it is essential throughout this report to not view statistical information as being exact. Instead, it can only serve to show relative trends and comparisons.

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(1) Marked by an asterisk in Appendix B.

CHAPTER II - PROGRAM DESCRIPTION

Introduction

This section describes the behaviour training programs in terms of: sponsorship; length of time in operation; size; perception of mandate; frequency of service; and duration of service. These descriptions are based on a combination of the questionnaire responses and discussions with staff.

Sponsorship

All programs reported that they receive 100% funding from the Ministry of Community and Social Services. However, they are operated under a variety of auspices, as indicated by the following Table.

Table 1

PROGRAM SPONSORSHIP (1)

- Association for the Mentally Retarded - 9
- Hospital or medical centre - 5
- Municipality - 3
- Community College or University - 3
- Family Services Association - 2
- Schedule I Facility - 2
- Children's Aid Society - 1

As would be expected there are perceived advantages and disadvantages associated with each type of sponsor.

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(1) Trent University's child and adult programs each reported separately since each has its own director and staff.

a) Association for the Mentally Retarded

Programs operating under the auspices of an Association for the Mentally Retarded reported, as advantages, that this:

- safeguards the priority of the developmentally handicapped client;
- puts the service in a situation where it is accountable to a community board. The board includes the parents of developmentally handicapped people so it not only understands their needs but also works to ensure that they are met by the program;
- facilitates linkage to other services operated by the Association and thereby increases the probability of continuity of care for the client;
- assists staff to keep up-to-date on new developments in the mental retardation field; and
- provides access to the services of the Association's case manager, thereby freeing program staff from this role which, in other programs, appears to be often assumed by the behaviour therapist.

Some of the disadvantages of being under this auspices reported by respondents were:

- the Association label is a concern to some parents, especially those of young children, since they feel it implies a final diagnosis which may not be appropriate;
- salaries tend not to be competitive, this may limit the potential pool of employees;
- there is a potential peer conflict if a staff member wants to suggest that changes be made to another program operated by the Association; and
- sponsorship by an Association may limit staff members' opportunities for consultation and information-sharing with behaviour therapists outside the mental retardation field. This could lead to narrowness of experience and outlook.

b) Hospital or Medical Centre

Programs sponsored by a hospital or medical centre reported the advantages to be:

- lack of parental concern about a mental retardation label since the service is generic;
- medical sponsorship gives an aura of credibility with other service providers. This is helpful when establishing a program;
- easy access to medical, speech pathology and other forms of consultation;
- reinforcement of the concept of normalization; and
- lack of peer conflict when making suggestions to services operated by an Association for the Mentally Retarded.

The disadvantages were reported to be:

- the priority of the developmentally handicapped may not be as safeguarded as it be would under an Association for the Mentally Retarded;
- the sponsor may not understand the needs of the developmentally handicapped, nor the issues of concern to this group; and
- the sponsor may not recognise the fact that social learning theory and practice are constantly changing, therefore, staff require on-going training.

c) Municipalities

Programs which are sponsored by municipalities also reported that being part of a generic service is an asset and noted that other advantages were:

- easy access to day nursery programs which, in turn, facilitates integration of children; and
- competitive salaries. This is perceived as enlarging the pool of potential staff.

However, these programs suggested the same disadvantages as did the hospital programs and, in addition, reported concern over lack of professional consultation, other than psychology.

d) Community College or University

The programs administered by a College or University appreciated the fact that they were perceived as non-threatening because of their association with an educational institution. In addition, they reported having easy access to library materials. On the other hand, like the municipal-sponsored programs, they feel a lack of professional consultation, other than psychology.

e) Family Service Associations

Agencies operated by Family Services Associations also recognised the advantages of being under a generic agency. On the other hand, one person suggested that this could work to the detriment of the client, since the developmentally handicapped is not the sponsor agency's target group. Also, respondents expressed concern that the salaries in these agencies tend to not be competitive.

f) Facilities

The programs operated by Schedule I Facilities noted there were advantages in the easy access to back-up services and competitive salaries with which to attract staff. However, respondents reported that there are also disadvantages, namely:

- the label associated with a Facility may distress some parents; and
- the available categories of the civil service staff classification system may limit choice in staff recruitment.

Advisory Committees

Some programs have an advisory committee. Generally this is composed of representatives from local Associations for the Mentally Retarded and other service providers. These committees monitor the program offered and make suggestions as to how it can be more responsive to community needs. Respondents stated that such a committee was useful and served to keep the program "honest". It would appear to be particularly helpful to programs which are operated by a sponsor other than an Association.

Length of program operation

Over half the programs have been in operation for four years or more. Two, Surrey Place and Ongwanada, were established in 1974.

Table 2

LENGTH OF PROGRAM OPERATION

date established	number of programs (1)
1975 or earlier	3
1976	1
1977	5
1978	3
1979	5
1980	4
1981	2
1982	1
1983	1

Size

The behaviour training programs are generally small. Data obtained during discussions indicated that some have only one behaviour therapist and the majority appear to have between three to five frontline workers. At the time of the survey over 850 clients across the province were receiving service.(2) Individual programs reported current caseloads ranging from 11 cases to 130.

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(1) The two Trent University programs are listed separately on this table since they were each established in different years.

(2) Based on only 19 of the 25 programs. This data was not available for those programs which used percentages to respond to all questions.

Perception of mandate

The questionnaire included a question on the program's objectives. Responses fell into the major categories illustrated by Table 3. Several programs indicated more than one objective.

Table 3

PROGRAM OBJECTIVES

Objective	Times mentioned
• train mediator to be a change agent	22
• maintain the client in the community	14
• lessen maladaptive behaviour	12
• provide consultation to other agencies	10
• develop adaptive behaviours	6
• change the client's environment so that it facilitates optimum functioning	3
• prevent re-institutionalization	3

The emphasis on mediator training; maintenance of the client in the community; and reduction of maladaptive behaviour is consistent with the Ministry's 1977 guidelines (Appendix A).

As noted in the following chapter (page 12) mandated clients are generally defined, at least for official purposes, as people who meet the definition in the Developmental Services Act. However, fourteen programs indicated that they are frequently asked to provide services for people who are functionally retarded, but do not meet the strict definition of the Act, (1) or for normal I.Q. clients with behaviour problems. Thirteen respondents reported feeling expected to provide case management or advocacy services. Other services perceived to be outside their mandate that programs reported having been asked to provide include: "hands-on" service for clients; assessment in situations where the program will not be providing a service; and family counselling.

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(1) The Developmental Services Act defines eligible clients as those whose retardation was present at birth or occurred during their formative years.

Frequency of service

Table 4 illustrates the reported frequency of service by programs. The data is separated out by child and adult clients.

Table 4

FREQUENCY OF SERVICE (1)

Frequency	Child	Adult
• once every 1 - 2 weeks	70%	57%
• once every 3 - 4 weeks	13%	19%
• once every 1 - 2 months	10%	16%
• less frequently	6%	8%

Respondents indicated that, particularly when working with children, they generally meet with the mediator once or twice a week. Then, after a few weeks, as the mediator begins to develop understanding of behaviour change principles and skill in their application, the therapist begins to reduce the frequency of contact.

Table 4 suggests that there are differences in the frequency of service depending on whether the client is a child or an adult. This may reflect the fact that with children the mediator appears to generally be a parent,(2) while with adults the mediator is often a staff person from a group home or workshop. There may be some feeling that the staff person can manage with less frequent visits, especially if the setting has used this type of behaviour change program with other clients.

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(1) The researcher was unable to convert percentage data into raw numbers for some programs which had responded to all questions with percentages. Therefore, all numbers were converted into percentages and an average percentage obtained for all the programs.

(2) There appears to be relatively little use of teachers as mediators. Some respondents suggested that there are difficulties using them because class size did not permit teachers to consequence behaviour consistently.

Duration of service

Table 5 illustrates average duration of service in behaviour training programs. This table is based on the actual number of cases in a twelve month period for all but 3 of the programs in the province. Two programs used percentages throughout and one did not submit data in response to the question from which this information was drawn.

Table 5

DURATION OF SERVICE

Timeframe	# cases	% of total cases
• 1 - 3 months	293	32.3%
• 4 - 6 months	215	23.7%
• 7 - 11 months	175	19.3%
• 1 - 2 years	165	18.2%
• over two years	57	6.5%

Table 5 indicates that 75% of cases are terminated within one year and 55% are terminated within 6 months or less. Two programs submitted data as percentages and these both indicated that 75 - 80% of their cases have a duration of 4 - 6 months.

In discussion, it was reported that the majority of cases lasting for two or more years involved situations of periodic contact by a parent who had been unable to generalize the principles and therefore sought assistance for each new issue. A number of these parents are, apparently, themselves developmentally handicapped. Other parents reported to have difficulty with generalization are those from multi-problem families. The perception of staff is that each time there is a crisis the mediator becomes inconsistent in consequencing the child with the result that the child's behaviour deteriorates. Some parents simply seem to need a periodic "booster dose" to help them remember the principles and to be consistent in their application.

CHAPTER III - SERVICE DELIVERY CHARACTERISTICS

Introduction

This chapter discusses service delivery characteristics of the behaviour training programs in terms of: admission criteria; selection and intake procedures; case termination criteria; drop-outs; readmissions; case documentation; and follow-up. The discussion is based on a combination of responses to the questionnaire and follow-up discussions with program staff.

Admission criteria

The original guidelines (Appendix A) indicated that the purpose of establishing the behaviour training programs was to assist developmentally handicapped individuals remain in the community. Programs' responses suggested that there is a general perception that clients should meet the criteria implied by the definition in the Developmental Services Act.

> " developmental handicap means a condition of mental impairment present or occuring during a person's formative years, that is associated with limitations in adaptive behaviour."
>
> Chapter 2, section 1 (c)

As a result several programs expressed concern because they are asked to provide service to people who may be functionally retarded, e.g. as the result of brain damage in adulthood, but do not meet the above definition. These people may have behaviour problems that threaten their acceptance in the community and the programs report that they have the technology to provide assistance.

Some agencies indicated that, in practice, they interpret the Act broadly and provide services to people who appear to be functionally retarded. Therefore, they have clients who sustained brain damage in adolescence or adulthood and also children who would be classified as functioning in the dull normal or borderline range of intelligence. Reponses to the questionnaire showed that only four programs had 100% of their clients with a psychometrically confirmed diagnosis of developmental handicap. The average percentage of confirmed diagnosis for all the programs as a group was 7[illegible]% with a median of 75%. It should be noted that some programs are part of a larger service which includes an infant stimulation program. These programs use the broad definition of "at risk" for all clients.

The availability and willingness of someone to act as a mediator is a formal criterion and major consideration for all programs. This is hardly surprising since the mediator model is the mode most often used for service delivery (see Table 8, page 21). In addition, several programs noted that they did not have sufficient staff to provide 1:1 service even if they wished to.

In discussion, only eleven programs indicated that they would never accept a case where there was not an identified person to act as mediator. Several respondents stated that they would consider such a case on its own merits and might make an exception in a special situation, for example, a Children's Aid ward where the Society believed that the child would have a better chance of finding a home if certain behaviours were changed. Respondents suggested that, in such situations, the program might try to obtain "special needs" funding through the local Ministry of Community and Social Services' Area Office. This would then be used to hire a contract worker to act as the mediator.

Most programs indicated that they did not have any behavioural exclusions. The exceptions were:

- psychiatric problem (4 programs);
- danger to self or others (3 programs);
- sexual deviancy (2 programs); and
- high frequency self-abuse (2 programs).

Other admission criteria generally pertained to age, since several programs reported having an upper age limit, in addition to the minimum age of two years suggested by the Ministry, and to geographic location.

Selection and intake procedures

Most programs reported accepting referrals from any source. Once a referral is accepted the program usually requires completion of a referral form which, to a greater of lesser degree, requests information on the client's development and medical history as well as data on previous contacts with the service system.

Several respondents stated that before making a final decision to accept the referral of a child the program does some type of family assessment. This assessment ranges from a comprehensive evaluation of family dynamics done by a social worker in one agency to, more commonly, a frontline worker from the program meeting with the family and trying to get a "feel" whether or not there are family problems which might preclude or interfere with successful use of the mediator model. The need to explore family dynamics to determine what type of intervention approach is appropriate is also reported in the professional literature (Freeman & Thompson, 1973; McKibben, 1972; Tymchuck, 1975).

Five programs reported that at the time of the survey they did not have a waiting list. All the others did and the reported size varied from a high of 70 clients to a low of 2. The average number of clients on a waiting list was 16 and the median was 10. Reported "waiting time" varied considerably from a low of 2 weeks to a high of 8 months. Several respondents stated that they used a priority system to determine who should be admitted from the waiting list when an opening became available. Generally priority lists were as follows:

- highest priority - client presents a danger to himself or others;
- second priority - client's behaviour is putting his current residential placement in jeopardy and may result in his being placed in an institution;
- third priority - the client is causing serious family disruption;
- fourth priority - the client's behaviour is likely to result in his removal from his school or work situation; and
- fifth priority - the client requires training in adaptive behaviour, e.g. self-help or social skills.

Additional considerations in establishing priorities for intake that were reported included: family dynamics; the chronicity of the problem; and age (with preference sometimes given to younger applicants). Because of waiting lists and the priority system, many respondents expressed concern that their staff spend most of their time dealing with negative behaviours rather than developing adaptive skills.

Case termination criteria

The two most commonly stated reasons for case termination were:[1]

- specific client goals are accomplished (92%); or
- the mediator is not following-through, e.g. is cancelling appointments, or failing to implement the program (44%).

Respondents reported that determination of whether or not goals have been reached is usually done through examination of numerical data, e.g. comparison of present functioning, as illustrated by behaviour frequency graphs, with baseline data.

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(1) Some programs use both criteria.

Several people, however, indicated that it is not sufficient to focus on specific goals for the client with behavioural exceptionalities and hope that the mediator has generalized. Instead the purpose of service delivery should be to ensure that the mediator understands behavioural change principles and has developed skill in their application. Therefore, some respondents suggested that a more appropriate criterion for termination was the mediator's understanding of the approach and ability to use it, not whether target behaviours had been attained by the client.

While at the time of intake it may appear that there is a mediator who is available and willing, the person may not actually follow-through. Then the program has to decide whether to terminate service or switch approach, perhaps to the provision of direct programming. One respondent stated that her program always starts with a three-month contract and a message to the mediator that the service will terminate after that period of time. In actuality, in this program, service is apparently often continued beyond the three months, but only if the mediator is showing gains in ability to use behaviour change principles, not on the basis of the client's progress. Two other respondents stated that, in their experience, if parents were not showing some ability to implement programs and generalize principles within 20 - 25 sessions they likely would never do so and this failure was an indication that the mediator model was inappropriate for the situation. However, exceptions to this "rule" include clients living in shift-staffed residences or mediators who are developmentally handicapped. Both these are apparently situations where a longer period is required to determine whether or not the mediator model is appropriate.

Drop-outs

Seven programs reported that they had not had any drop-outs in the previous twelve month period. Other respondents' answers indicated that there had been a total of 97 drop-outs across the province, with a range from 2 - 23 and an average of 4, per program. Reasons for dropping-out do not appear to be associated with any particular type of client goal. Dropping-out is, however, perceived to occur with greater frequency in certain situations. The most frequently cited were:

- a multi-problem family where the parent feels over-whelmed by the demands of being a mediator;
- a parent who is "burned-out" and/or resentful of the child and therefore not "psychologically ready" to assume the mediator role;
- both parents work full-time and, as a result, they experience the expectations of being a mediator as too demanding; and

- the referral came from a source other than the mediator and the mediator was really looking for direct service.

Less frequently cited situations were those where one parent is willing to be the mediator but the other does not wish to be involved and offers no support, or the family has a crisis which requires a different type of intervention.

Readmissions

Five programs reported that they had not had any readmissions during the previous twelve month period. Other respondents' answers indicated that there had been a total of 86 readmissions across the province, with a range of 1 - 11 and an average of 3. The main situation in which a readmission appears to occur is that of a parent who may have implemented a program satisfactorily but did not generalize the principles. Therefore, when another issue arises, the parent has to again seek assistance.

Case documentation

Information on documentation in the files was obtained through the questionnaire and supplemented in the follow-up discussions as necessary. No files were examined by the researcher. Eight respondents stated that they based their estimate of what would be in the files on the basis of a file audit and that such a procedure was a regular part of the program's administration. Two people indicated that they had done a spot check of their program's files for this study. In the other situations the report appeared to be based on the respondent's estimation of what should be there.

As indicated by the table on the following page, although the original Ministry guidelines stated that a medical examination is necessary before a program is implemented, only 4 respondents stated that all files would contain a medical report. A number of people indicated that medical reports were only requested on an as-needed basis if the therapist had some concerns. There are common disabilities, such as marginally defective hearing, which may effect an individual's behaviour but would be difficult for a lay person to identify. Therefore, it is probably desirable that at least children have a medical screening before a program is implemented. Appendix D presents an example of a screening form sent by one program to the family doctor after it has decided on the probable intervention that will be used with the client.

There appears to be a growing awareness of the possible effect of family dynamics on the ability of a parent to be a successful mediator. Therefore, it is not surprising that 11 programs (nearly 50%) reported that 75% or more of their files would contain a family history. Since some clients would be adults this suggests that such information is collected on most child clients. Six other programs indicated that such information would be obtained if the worker had questions about family functioning.

Ten programs indicated that there would be no follow-up material in any files. This reflects the apparent reality that many programs feel that they only have the capacity to do very limited follow-up. Therefore, they rely on the mediator to initiate contact if there are any problems after discharge.

Table 6

CASE DOCUMENTATION

Data type	Estimated percentage present and complete
• referral form	virtually 100%
• medical report	14 programs reported over 50%, 5 indicated 100%
• family history	10 programs reported that 75% or more of their files would have this
• individual treatment plan	virtually 100%
• mediator training plan	virtually 100%, either as a separate document or as part of the IPP
• progress notes	virtually 100%
• termination summary	virtually 100%
• formal follow-up information	10 programs reported none, others estimated 50 - 85%

Follow-up

The majority of programs report using gradual reduction of contact when terminating a case. Some feel that this enables staff to be aware of the mediator's response to withdrawal of service and provides an opportunity to resume more intensive work if necessary. Reported practice in regard to follow-up varies. However, the most common method, as indicated by eleven programs, seems to be a telephone call during which informal, rather than structured, information is collected. A couple of respondents expressed concern about this but indicated that time constraints did not permit anything more intensive. Five programs reported that they visited at 3 and 6 months after discharge, two programs reported one visit to the mediator after the case was terminated. Another program stated that it visited the mediator every two weeks for two months and then once a month for two months. The remaining programs appear to have no regular follow-up procedure.

CHAPTER IV - PROGRAMMING CONTENT

Introduction

This chapter describes the programs in terms of: client goals; mediator goals; major modes of service delivery; major locations of service delivery; training packages; and monitoring procedures.

Client Goals

Table 7 illustrates the most common types of goals which the behaviour training programs reported they were addressing. The table refers to the percentage of clients that have a particular goal. The data represents information as reported by 23 programs for children and 17 for adults. Most clients have more than one goal and not all goals which were being addressed by programs across the province are included.

Table 7

MOST COMMON GOALS BEING ADDRESSED

Goal	Child	Adult
• development of:		
- self-care skills	21%	22%
- communications skills	11%	10%
- social skills, e.g. impulse control, peer relationships	5%	4%
- community living skills, e.g. use of public transportation	1%	8%
• decrease in:		
- non-compliance	26%	18%
- aggression	18%	25%
- bizarre or stereotyped behaviours	5%	9%
- self-injurious behaviour	2%	4%
- hyperactivity	6%	1%

The most frequent goals for both children and adults are:

- decrease in non-compliance;
- decrease in aggression; and
- development of self-care skills.

All these goals directly address the ability of the individual to function in, and be accepted by, the community. In particular, decrease of aggression in adults could be expected to contribute to reduction of possible institutionalization.

Mediator goals

Almost all the programs indicated that a mediator training plan was developed, either as a separate document or as part of the client's IPP. From discussion with respondents it would appear that the mediator goals generally involved development of an understanding of behaviour management principles and the ability to use them to develop and implement programs which would address specific client targets.

Major modes of service delivery

In discussions with respondents it became apparent that there was considerable over-lap in interpretation between the following two items from question E-1, page 5, of the questionnaire (see Appendix C).

- joint programming with the mediator and client in his home, school or place of work; and
- training of the mediator only.

It appeared that people indicated use of the former if their mediator training included demonstration and modelling for the mediator with the client and/or a significant amount of time spent directly observing the mediator work with the client. Other programs, which seemed to rely more heavily on instruction to the mediator, with less direct contact between the behaviour therapist and the client, tended to use the latter item. In both cases the items indicated treatment of the client primarily through the mediator rather than through direct work by program staff. Therefore, in the table on the following page, these two items are combined.

Table 8

PERCENTAGE (1) OF CLIENTS WITH WHICH EACH MODE OF SERVICE USED

• joint programming with the mediator and client in his home, school or place of work	92%
• individual programming for the client only in his home, school or place of work	3%
• group programming for mediators only	2%
• individual programming for the client only conducted in the agency	1%
• group programming for clients only	1%
• joint programming with the mediator and the client in the agency	1%
• consultation to staff of other agencies	1%

Table 8 indicates that the majority of clients are receiving treatment through a mediator. The number of programs by percentage of current caseload being treated through a mediator is illustrated by Table 9.

Table 9

FREQUENCY OF USE OF THE MEDIATOR MODEL

Percentage of current cases	No. of programs
• 50 - 59%	2
• 60 - 69%	3
• 70 - 79%	1
• 80 - 89%	5
• 90 - 100%	14

(1) All raw numbers were converted into percentages and then an average obtained for all the agency percentages in each mode.

Ten programs reported some use of individual programming with the client only. This mode appears to be used in one of two very specific situations, namely:

- a highly intensive intervention, such as the Foxx-Azrin toilet training program; or
- use of a contract worker through "special needs" funding in a situation where the child's behaviour puts him in jeopardy of removal from his current situation, but there is no appropriate mediator available.

Both situations are expected to be of short duration and the hope is that the people in the natural environment will be able to maintain the program after the target behaviour in brought under control.

Group programming for mediators only may refer to training staff in other agencies, e.g. a group home, in the principles of behaviour change in general or group training of parents to be mediators for their child. Six agencies reported routine use of parent group training. This approach appears to be used for the following reasons:

- to handle a waiting list so that parents feel that they are getting some response, even if a behaviour therapist is not available to begin individual work with them on behalf of their child. One program reported that it automatically starts a parent group when the waiting list is six or more. Respondents reported that a few parents learn enough in this situation to begin programming themselves and to do without individual service provision;
- to be cost/efficient since this mode allows one staff person to train several parents simultaneously. When a therapist is available the parents know the principles and can begin implementing a program immediately; and
- to weed out parents with low motivation or who are not comfortable with the operant conditioning approach before a lot of time has been invested by a therapist visiting the home.

Some of the advantages mentioned by respondents using this approach on a regular basis are:[1]

- parents are less likely to take the illustrations used personally;
- parents reinforce each other to continue and may learn from hearing discussions about each other's child; and
- the approach enables the use of role playing so that parents can literally "see" the idea. This lessens reliance on written material.

Respondents also noted the following disadvantages:

- a group setting may intimidate some parents, e.g. those who are low-functioning or poorly educated;
- it is sometimes difficult to get a reasonably homogeneous group, e.g. parents whose children are all about the same age; and
- some parents may have difficulty getting a baby sitter for other children or arranging transportation.

Suggestions given to overcome some of the above potential problems included:

- tailor the course to fit the group, e.g. with lower-functioning or less-educated parents make use of tape-recorded sessions, role-playing, modelling, etc. and rely less on written materials;
- keep classes informal and small so as to lessen the likelihood of people feeling intimidated. One program holds classes in a parent's house and pays the parent to supply coffee; and
- establish a car pool whereby parents provide transportation for each other.

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(1) People who reported running regular parent groups and who cited positive advantages in using this method included Leanne Baldwin (Peel) and Dorothy Griffiths (York).

A couple of respondents who use this approach warned that not all parents are able to assimilate information in a group. Therefore, there will always be some who require individual instruction. Several people noted that parent group training sessions cannot simply focus on teaching principles and techniques. In order to get the most benefit from this approach it is necessary to recognise that there is a group process in operation and to take advantage of it, e.g.

- to support peer pressure to encourage parents to complete homework assignments; and
- to deliberately set up situations where a parent (rather than the staff person) identifies the solution to a problem which is being discussed.

There was also emphasis on the importance of developing parental observational skills and ability to define the problem before focusing on specific techniques.

Individual programming with the client in the centre was reported as occasionally used by four centres. It appears to be usually used with adults to either train social skills or, as will be described in more detail on page 57, to train the client to be his own mediator.

Group programming for clients appears generally to include either application of a token economy in a group home or teaching social and life skills. In the latter situation, for example, a cooking class or recreational sports activity, the group is reported to provide a more realistic method of teaching inter-action skills than does a mediator/client situation.

Three programs reported some joint programming with the mediator and the client in the agency. The situations described involved either:

- use of video to show the mediator what he was doing; or
- use of a one-way mirror with a "bug-in-the-ear" to give immediate feedback to a mediator implementing a program with a client.

In all situations work with the dyad in the agency setting was an adjunct to programming in the natural environment.

Major location of service delivery

For child clients the home appears to be the major location in which intervention is undertaken. However, programs also indicated that staff work with mediator/child dyads in day care settings, nursery and other schools, summer camps and a Crippled Children's Centre. Adults also appear to receive the majority of their programming in the home, with the client's place of work being the second most common location for service delivery. The breakdown, as reported by the sixteen programs which submitted numerical, as opposed to percentage, data was:

	Child	Adult
• own home	678	157
• client's other setting	267	88

There are, included in the above, some situations where a client will receive programming in both his home and another setting.

Training packages

None of the behaviour training programs appears to be "locked into" any specific set of training materials. On the contrary, many respondents indicated the need to use individualized approaches tailored to meet the client's unique situation. In fact, a total of 29 different training packages or textbooks were identified as sometimes being used. Of these, only 9 were reported as being used by more than one program and only 5 used by more than 2 programs (see Table 10, following page). Nine programs reported that they never use standard training packages or parent training texts but instead rely completely on "home grown" materials.

The range of programs being used confirms the viewpoint that it is desirable to use an individualized approach. However, it may also suggest a lack of identification by some programs of effective tools that do exist. Twenty-six commercially available parent training manuals using the operant conditioning approach were described in a review by Bernal and North (1978). One of these manuals, Steps to Independence: A Skills Training Series for Children with Special Needs (Baker, Rightman, Heifetz and Murphey, 1976), was written specifically for training parents of developmentally handicapped children. This manual discusses various behaviour change principles and their application and includes sections on managing behaviour problems as well as on development of self-help skills. A companion guide is available for staff using this material in parent training.

Table 10

TRAINING PACKAGES AND PARENT TEXTBOOKS

Material	Programs using
• Never use a standard package	9
• Portage	6
• Vulpe	4
• Patterson "Families"*	3
• Becker "Parents are Teachers"*	3
• Foxx-Azrin toilet training package*	3
• Oregon Social Learning Centre compliance training package	2
• Foxx-Forehand training films	2
• Baker et. al. "Steps to Independence"*	2
• parent training course, York Behaviour Management Services	2

Monitoring procedures

Most programs reported that they attempt to have the mediator collect behaviour frequency and/or duration counts. However, as is discussed in Chapter VIII, mediator data collection can sometimes be problematic. Nevertheless, 16 of the 25 programs supplying data on their methods of monitoring client progress use mediator generated data for this purpose. It is, however, generally supplemented, at least part of the time, by data generated through direct staff observation. One person noted that there is a potential problem with having the therapist go in and do spot data collection, namely, the possibility that the client might be having a bad day. The other most frequently reported method of monitoring progress, as illustrated by Table 11 on the following page, is through verbal feedback from the mediator.

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* Reference cited in the bibliography.

Table 11

METHODS USED TO MONITOR CLIENT PROGRESS

Method	Times Mentioned
• direct observation by the therapist	17 (68%)
• mediator-generated data	16 (64%)
• verbal feedback from the mediator	11 (44%)
• AAMD Adaptive Behavior Scale	5 (21%)
• Goal Attainment Scaling	3 (13%)
• Other methods	7 (29%)

Other methods reported, in addition to the above, included the use of pre-and post-test scores on various developmental tests.

The method cited as the most useful for monitoring programming was mediator-generated data (10 of the programs), followed by a combination of data obtained through staff observation and data collected by mediators.

CHAPTER V - STAFFING PATTERNS

Staff hiring criteria

Most programs responded to the question "what do you look for when hiring paid staff?" by first delineating the personal characteristics they sought in potential staff members before discussing academic qualifications or past work experience. Several respondents stated that personal characteristics were the major criteria since an individual could always be taught learning theory and its applications. A number of programs indicated that they had no particular preference for type of academic qualifications.

Table 12

CRITERIA FOR STAFF SELECTION

criterion	times mentioned
• personal characteristics	
- ability to work independently	9
- good communication skills	9
- personal warmth, ability to establish rapport with mediators	6
- ability to be supportive with mediators	5
- flexibility	5
• previous experience	
- work with the developmentally handicapped	15
- knowlege of and/or experience with learning theory	9
- experience in adult or parent education	7
- experience in family counselling	3
• academic qualifications	
- minimum B.A. or equivalent (e.g. community college or certificate in M.R.)	13
- minimum M.A.	1

Staff turnover

The data on staff turnover rate for the past two years indicates that most behaviour training programs have experienced remarkable stability in staff.

Table 13

STAFF TURNOVER IN THE PAST TWO YEARS

Turnover	# of programs
• none left	11
• 1 - 2 left *	10
• 3 - 4 left **	2
• 5 or more left	0

* Several respondents indicated that only one person had left. In three cases the reason was maternity leave.

** In one program all the people who had left had gone to establish behaviour training programs elsewhere. In the other situation two of the four people who had left had gone to other programs, and one had gone on maternity leave.

The above suggests that in spite of irregular hours, and a job that requires a large percentage of time working in isolation from other staff, frontline workers find the job satisfying. One respondent hypothesized that the learning theory approach enables the worker to identify even small gains. It also provides constant feedback that the effort being made is making a difference.

Staff activities

Table 14, on the following page, indicates that approximately 36% of staff time across the province is spent in direct interaction with the mediator/client dyad. An additional 27% of staff time is spent in case planning, case review and report writing. Therefore, almost 2/3 of the available staff time is spent in direct client-related activities.

Travel occupies the next largest amount of time on a province-wide basis. However, the percentage in individual agencies varies considerably depending on the size of the catchment area.

Some rural programs, especially those serving a whole county, spend almost as much time travelling as providing service. A couple of programs in this situation indicated that they had given serious consideration to cutting down staff travel time by having mediators come to the centre. However, this was reported as often not feasible because a parent lacks transportation and/or a babysitter. This appears to be particularly true in poorer rural areas. Some programs with a large rural catchment area have addressed this issue by opening up satellite offices.

Table 14

STAFF ACTIVITIES

Activity	% of time	range
• visits to mediator/client		
- in family home	25%	10 - 50%
- client's other setting	11%	0 - 27%
• case planning and review, report writing	27%	11 - 59%
• travel	13%	8 - 30%
• staff supervision and training (own program)	7%	0 - 15%
• assessment	6%	0 - 20%
• consultation to and staff training in other agencies	6%	0 - 15%
• general community education	2%	0 - 6%

A surprisingly small amount of time appears to be spent in staff development, either within the program or for other agencies. As previously noted, some respondents suggested that time spent training staff in group homes, schools and workshops paid off if later the staff became involved in programming for a specific client. Other programs indicated that they believed this was not a good use of time, especially in group homes, because of the high staff turn-over. Therefore, they perceived it to be a better use of the behaviour training program's staff time to wait until service was being provided to a client in one of the other settings.

Staff training needs

Only three respondents stated that their staff had no training needs. Most, on the contrary, expressed concern that their programs were not able to offer sufficient staff development. Table 15 illustrates the main areas where staff training needs were identified.

Table 15

STAFF DEVELOPMENT NEEDS

Need	Times mentioned
• opportunities to learn about new techniques	14
• family assessment and family dynamics	8
• child development	4

Respondents noted that the use of learning theory applications to change behaviour is still relatively new. As a result new techniques are constantly being developed and old ones refined. Therefore, in order to provide high quality service, it is necessary for frontline workers to keep up-to-date with new developments in the field. Such information is generally first disseminated through workshops and conferences, these often occur in the United States. However, several people stated that their budget for staff development is not sufficient to permit workers to be sent to these conferences. Staff can obtain information from journals, however, this is not viewed as effective since there is often a significant time lag between development and testing of a technique and publication. In addition, journal reading does not provide an opportunity to discuss issues with others in the field on a face-to-face basis. Respondents stated that the Ministry needs to be aware of the importance, for a program using learning theory, of keeping up-to-date on new developments.

There appears to be a growing conviction among programs that have been operating for several years that learning theory cannot be implemented in isolation. The mediator model is viewed as being only as good as the mediator who, in turn, is affected by family dynamics. Therefore, the frontline worker needs some skills in family assessment and responding to family dysfunctioning. Most workers in behaviour training programs have been trained in learning theory, but not in counselling or family therapy. This is the reason for a perceived need for staff development in family assessment and dynamics.

Other training needs that were identified by several respondents were client assessment, neuropsychology and information on drugs.

Use of consultants

All programs, except one, have access, on a regular basis, to the services of a registered psychologist. The program lacking this resource stated that there was not such a person available in the area where it is located.

In spite of the fact that the original Ministry guidelines stated that all programs should be reviewed by a psychologist before implementation, eleven programs reported that they did not do this.

Some programs which do have all IPPs reviewed stated they did not think it necessary. The most commonly expressed reasons for having all IPPs reviewed were:

- to protect the client's civil rights. This was believed to be done by having a second opinion from someone not directly involved in service provision, and therefore objective;
- to protect the frontline worker from liability; and
- to ensure that appropriate procedures are used.

One person suggested that with Facility closures there will be more severely disturbed people in the community and therefore a greater need to have a psychologist review all programs.

Reasons for not requiring all IPPs to be reviewed by the psychologist usually reflected concern that this was not the best use of a scarce resource. For example, in some situations it might be more important to have psychological consultation around family dynamics. There was concensus that IPPs should be reviewed if they involved aversive techniques. In addition, some people felt it desirable to either have specific pre-determined criteria to provide guidance as to when an IPP should be reviewed and/or have the psychologist do spot checks. A group of community-based service providers (1) is developing a position paper on the use of learning theory techniques. An early draft of this paper suggests that:

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(1) Denise Dolff (Cambridge), Jacki Martins (Halton), Fran Owen (Niagara), Leanne Baldwin (Peel), Nancy Malloy and Scott Gardiner (Walkerton) and Dorothy Griffiths (York).

- every program should have the services of a registered psychologist who has knowledge and experience in the use of learning theory; and

- the psychologist should review, approve, authorize and evaluate all programs that are restrictive and/or punitive. Included in this definition is extinction, restitution, overcorrection and time-out.

A few programs, particularly those associated with hospitals, have access to other types of consultation, such as, speech therapy and physiotherapy. Most programs do not. Respondents indicated that it would be especially useful to have consultation in family dynamics. Two programs have social workers as part of their staff, while a few others have access to a social worker through their sponsor, usually an Association for the Mentally Retarded. Most programs, however, do not have this type of resource. As previously noted some respondents reported that their frontline workers do informal counselling, even though they are not trained in this. The availability of appropriate consultation and supervision would clearly be helpful in those situations that require formal counselling techniques.

The other type of consultation which was identified as being particularly needed was speech and language therapy. A couple of people suggested that aggression often stems from a communication problem. In such cases a pure learning theory response is inappropriate.

Use of volunteers

There appears to be relatively little use of volunteers. The majority of programs indicated that they did not use volunteers because there would not be sufficient pay-off for the amount of time necessary to provide training and on-going supervision. A couple of programs also expressed concern about liability. However, five programs do use volunteers for the following purposes:

- to act as a friend for an isolated parent (2 programs);

- to act as a reward agent with social/recreational reinforcers, e.g. to take a client bowling (2 programs);

- to provide transportation (2 programs);

- to work directly with clients (2 programs); and

- to provide baby-sitting (1 program).

There appears to be general concern about the ethics of using volunteers to work directly with mediators. One situation where volunteers provide direct service for clients involves the use of high school students who make a ten week committment in partial fulfillment of a course. These students are given a 5 hour course in learning theory, then used on a 1 to 1 basis with clients in group skill training situations under constant and on-going supervision of a staff member. The program using high school students in this fashion reported that it has found it to be a positive experience. Apparently students often continue to provide service beyond the ten week time committment and in a couple of cases have subsequently been used to work directly with clients under a special needs agreement. The other program which reported using volunteers to work directly with clients only uses them in highly structured academic training situations, e.g. implementation of Distar programs.

Three programs reported the use of college or university students on practicum placements. In one situation training and supervision is provided by the professor who also happens to be the program's consultant psychologist. The students are then used to provide mediator relief, generally in residences or workshops, under the on-site supervision of the mediator. The students serving practicums in the other two agencies are provided with training and supervision by program staff. One program reported that this is the first year that it has had students and it was not sure how it would use them. The other program has had students previously and stated that the service they provide barely covers the "cost" of training and supervision.

Several programs noted that "graduate" parents, i.e. parents who have successfully completed a mediator training program, often wish to volunteer. This would appear to be a valuable, but presently under-utilized, resource. It might be appropriate to use graduate parent volunteers in the following ways:

- to provide role models and morale support to isolated parents, thereby giving them encouragement to stay with the program;
- to act as co-therapist in group training of mediators or clients;
- to be a reward agent for clients; and
- to act as a peer model/friend for clients.

Use of graduate parents in this fashion might reinforce them to continue using learning principles and practices. It may also be a cost-effective way of providing assistance to the therapist.

CHAPTER VI - PERCEIVED PROGRAM STRENGTHS AND AREAS OF CONCERN

Program strengths

A wide variety of program strengths were cited, but only a few were identified by more than one program. Table 16 illustrates the strengths that were most commonly reported.

Table 16

PROGRAM STRENGTHS

Strength	Times-mentioned
• use of the mediator model	9
• flexibility, willingness to adjust programs to meet the client's needs	9
• coordination with other services in the community	8
• qualified, competent staff	8
• availability of good consultation and back-up resources	7
• use of learning theory and the fact it provides specific techniques	5
• provision of service in the natural environment	3

Respondents most freqently viewed these strengths as being the result of:

- low staff turn-over, which resulted in a group of experienced workers;
- staff commitment;
- effort put into determining what the community needed, and then trying to provide that service; and
- staff willingness to examine what works or does not work.

Program concerns

There was considerably less diversity in the concerns cited by respondents, and more of the concerns were reported several times. The main concerns identified are shown on Table 17.

Table 17

PROGRAM CONCERNS

Concern	Times mentioned
• long waiting list (1)	11
• need for additional staff	9
• insufficient time and money for adequate staff development	7
• amount of time spent travelling	3

The key ingredient contributing to the above concerns was identified as inadequate government funding.

The concern regarding shortage of staff is probably related to the concern about waiting lists. As noted earlier, 20 of the 25 programs reported having people waiting for service.

The concern about staff development is not surprising. Several respondents noted during discussions that behaviour modification techniques are constantly being refined and it is essential to keep up to date with the latest developments in order to provide quality service. In addition, there is a growing conviction that learning theory is not always enough. In many situations it is necessary for the behaviour therapist to have some understanding of family dynamics. However, most behaviour therapists have not had much training or experience in this area.

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(1) Three programs also expressed concern that waiting lists will become even longer as a result of the closure of Facilities.

Unserved client groups

Twenty-one of the 25 programs indicated that they were aware of client groups which should or could be using their service but were not. The client groups identified are shown in Table 18.

Table 18

UNSERVED CLIENT GROUPS

Group	Times mentioned
• developmentally handicapped:	
- people served by other agencies which have a practice of non-referral, e.g. some group homes	7
- adults	4
- adolescents	1
• non-developmentally handicapped:	
- normal I.Q. children with behaviour problems as a result of inadequate parenting (parents lack skills)	8
- people who are functionally retarded but don't meet the criteria in the Act	5
- autistic individuals	1

The reasons cited for lack of service to the above groups were:

- the clients are not part of our mandate, e.g. our program serves only children, the clients do not meet the criteria of the Act;
- staff in some agencies do not perceive that they need assistance from others; and
- we have a waiting list and think that we must give priority to people who meet the admission criteria.

Several respondents indicated that they felt particularly strongly that their program should serve the non-developmentally handicapped clients identified. They are viewed as having the same sorts of needs as the developmentally handicapped, and likely to benefit from the same approaches.

Services for discharged clients

Two of the 25 programs indicated that there were sufficient services for discharged clients. The most frequent need, which was reported by twelve respondents, is community support services, such as Adult Protective Service Workers and day programming. Seven programs commented on the difficulty they experienced trying to obtain appropriate community residential placements for adolescents and adults. Other needs that were reported included psychiatric or counselling services for people who are both developmentally handicapped and emotionally disturbed, specialized assessment and training in communication, and appropriate school programming for children.

Provision of case management services

Fifteen of the 25 programs indicated that their staff regularly pick up the role of case manager for their clients. The most frequently cited perceived reasons for this were:

- no-one else is doing it so it falls to us by default (eight programs);
- staff are generally the only workers involved with the family who also visit the home. This appears to encourage a trust relationship so parents naturally turn to the behaviour therapist for assistance in finding other needed services (six programs); and
- the Adult Protective Worker's caseload is too large (three programs).

One program noted that approximately 90% of its clients have neither a Family Support Worker nor an Adult Protective Services Worker. Therefore, the behaviour therapist feels that he has to fill the gap. Some respondents expressed concern that the behaviour therapist picked up the role of case manager. A couple noted that the intent of the behaviour management service is to train the mediator to be independent and then terminate contact. It is not intended to provide long-term support. Therefore, they concluded that it was inappropriate to be assuming the case management role. However, if the situation looks as if on-going case management will be required, they attempt to link the client with a Family Support Worker or Adult Protective Service Worker.

Other respondents expressed concern about the time that the case management role can take. They believed that this was not an appropriate use of a behaviour therapist, especially if the program has a waiting list. It does appear, on the basis of discussions, that there may be considerable variation from one part of the province to another in the availability of case management services. This could explain why some behaviour management services feel compelled to provide this type of assistance to their clients.

The ten programs which reported that their staff do not pick up the case manager role appeared able to obtain that service for clients from other sources because they:

- were under the auspices of an Association for the Mentally Retarded, which would provide a Family Support Worker or Adult Protective Services Worker;
- were administered by a Facility and the Facility would provide or obtain a case manager; or
- had access to a Municipality's case manager program.

Community relationships

All programs reported on-going involvement with other agencies in the community on case-related issues, e.g. exchange of information, joint case conferences. Several respondents indicated that they regularly conduct general workshops for staff in other agencies. However, from information obtained through the questionnaires and follow-up discussions, it appears that relatively few programs are involved in inter-agency committees or service planning bodies that concern themselves with broader community service delivery issues (see Table 19, below).

Table 19

COMMUNITY RELATIONSHIPS

Involvement	Times mentioned
• regular formal meetings with the coordinators of the community support programs for the developmentally handicapped (1)	3
• membership on a generic inter-agency committee	3
• membership on the District Working Group	1
• staff member is on the Board of another agency	1
• staff member is on the Board of the Association for the Mentally Retarded	1

(1) Reported by programs which are under the auspices of an Association. In such situations the other community support services may be under the same auspices.

As is illustrated by Table 19, most involvement in inter-agency or service planning groups is associated with service delivery to developmentally handicapped people. This is somewhat surprising since a number of respondents mentioned the desirability of contact with people serving other types of clients in order to to maintain a reasonably broad outlook.

CHAPTER VII - PROGRAM EVALUATION

Introduction

In order to determine the methods used to evaluate the performance of the service as a whole, in contrast to success with individual clients, respondents were asked to indicate:

- how their program evaluates the effectiveness(1) and the efficiency(2) of the service as a whole;
- which methods they had found to be most useful; and
- what program research had been done.

Program effectiveness

The most commonly reported methods used were:

- examination of the percentage of success in reaching client goals (23 programs);
- measures of mediator satisfaction (21 programs); and
- percentage of estimated cases in which there was improvement in the client/mediator relationship (18 programs).

The two methods considered by far the most useful were:

- percentage of cases in which client goals were reached (16 programs); and
- mediator satisfaction (8 programs).

The analysis of the percentage of cases in which goals are reached is apparently done through examination of numerical data, such as frequency counts, as much as possible. Mediator satisfaction is sometimes based on the use of questionnaires sent out shortly after termination of service (see Appendix E).

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(1) Ability to produce desired results.

(2) Production of desired results in a way which makes the best use of available resources.

People using this approach warn that return is often poor, one program estimated that spontaneous return, that is, without a reminder, was generally only 35%. Therefore, it is necessary to also institute a "bring-forward" system, which will remind the worker to follow-up by telephone if the questionnaire is not returned.

Program efficiency

Since programs can be effective, but not be efficient, respondents were also asked to indicate how they evaluate the efficiency of the service as a whole. The two most frequently reported measures were:

- staff time utilization (8 programs); and
- number of clients served in a given time period (6 programs).

Examination of staff time utilization was perceived to be the most useful measure. Appendix F presents the definitions used by one program to define staff activities for analysis. Appendix G presents a sample of a form to be used by frontline staff to record their expenditure of time on different activities. Interpretation of such information requires knowledge of the community, as well as of the program. For example, what may appear to be excessive amounts of time spent travelling in one situation, will not be in another where the catchment area is larger.

People using examination of the number of clients served in a given time period reported that basically they check to determine whether the program is serving as many clients in this quarter as it did in the previous one. If not, it is then necessary to determine why. For example, is the percentage of new clients requiring intensive work greater this quarter than it was last.

Program research

Several people suggested that the aggregate client data across the province should be examined to asses what techniques work with different types of clients. There appeared to be a strong feeling that this information might contribute to a more effective and efficient use of resources.

No programs reported having done any research. However, two programs reported having research in progress. Surrey Place Centre is currently analyzing data which it hopes will identify correlations between outcome and both client and mediator type. Trent University has recently hired a researcher to begin examining its data to determine what information might be extracted from it.

CHAPTER VIII - LESSONS FROM EXPERIENCE

Strengths and weaknesses of the mediator model

Without exception respondents viewed the mediator model (1) very positively and stated that it was ideal when it worked. However, as several commented, the model is only as good as the mediator and it is not appropriate in all situations.

The strengths of the mediator model most freqently cited were:

- provides an approach which allows for changing the environment and establishing environmental mechanisms which will enhance maintenance of new behaviours. Thus the mediator model addresses the fact that the environment often contributes to the development and maintenance of problem behaviours;

- allows the therapist to work on behaviours in the context in which they occur. This lessens the need for generalization and increases the likelihood of success;

- the mediator is made part of the solution and therefore feels better about the situation and the client. In families this increases the likelihood that the client with a behavioural exceptionality will be maintained at home;

- the mediator is with the client for much of the time and therefore can consequence behaviour more consistently than would be possible through direct service provision. As a result behaviour change occurs more quickly; and

- the mediator learns skills which can be used in other situations with the client or with other clients with whom the person is involved. This is a more cost/effective use of the behaviour therapist than is direct service provision.

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(1) Training an individual in the client's natural environment to implement a treatment program.

However, the mediator model is perceived as perhaps not appropriate in 20 - 25% of cases. These are situations where:

- the potential mediator experiences the model as highly intrusive and an invasion of privacy;
- a suitable mediator is not available:
  - the client is living independently in the community and staff in his day program are not prepared to act as mediators;
  - the potential mediator is burned-out and lacks the inner resources to take on mediation;
  - the potential mediator is not comfortable with the philosophical approach being proposed;
  - the mediator is under stress and has too many unmet needs;
  - the potential mediator really does not want assistance, e.g. is reluctant to admit the need for help, was looking for direct service;
  - the client is not attached to the potential mediator and/or not susceptible to the influence of praise, e.g. a CAS ward who has had frequent moves; or
  - there is a language and/or cultural barrier between the potential mediator and the therapist;
- the client is sufficently high functioning that it is more appropriate to work directly with him, and put the locus of control for his behaviour in his hands, rather than foster dependence on another.

The mediator model is reported as often difficult to implement when:

- the potential mediator is an elderly parent of a middle-aged person living at home. In such situations it may be difficult to change underlying attitudes or the parent's approach to the behaviour of the client; or
- the mediator feels that since the therapist is being paid by the agency he should provide direct service.

Respondents stated that they try to arrange direct service if they feel the potential mediator is simply burned-out and needs some respite, but will later assume responsibility. However, provision of direct service is very difficult for programs with only one or two staff members, and in situations where the availability of special needs funding through the Ministry is limited. If the barrier appears to be the potential mediator's own unmet needs, many programs will either divert the individual to counselling or try to provide concurrent counselling while implementing behaviour management training. Respondents suggested that sometimes the most appropriate reaction is to frankly discuss the situation with the potential mediator and then terminate involvement.

Learning theory is not always sufficient

Six respondents noted that initially they tended:

- to perceive target behaviours as deficits in the client which could be successfully addressed by the use of behaviour management techniques in isolation; and

- to insist that a "pure" model of learning theory, that is, one as close as possible to that cited in the experimental literature on behaviour modification, must be used with all cases.

They reported now believing that:

- it is essential to be sensitive to other factors in the client's environment, e.g. family dynamics, which might be influencing behaviour. Responding only to the identified problem, without looking at the context, is likely to result in failure; and

- flexibility is the key to success. It is essential to attend to what the client and the mediator need and to tailor the approach to fit the situation. It is also necessary to be realistic about what can be accomplished in any given case, e.g. the mediator's ability to collect data or to implement a certain type of program.

Significantly, the respondents who were most emphatic in stating that behaviour modification in isolation, or always implemented in a "pure" fashion, may sometimes be inappropriate tended to be associated with the programs which have been in operation the longest. Particular concern was expressed that learning theory implemented in isolation focuses attention (blame) on the client

and gives both the mediator and the therapist an excuse not to examine the effect of environmental factors. Some people suggested that families under stress, for example, experiencing marital discord, may focus on the child's behaviour rather than address the real inter-personal issue. There appears to be a growing conviction, at least among some service providers, that before implementing a program based on learning theory it is essential to assess the client's environment to determine if another approach is more appropriate.

A mediator model using only learning theory was reported as most likely to fail if:

- the mediator is an "insular mother", that is, one who is socially isolated and therefore lacking emotional support;
- the mediator is highly stressed, depressed, or resentful of the client and, because of his own unmet needs, is not psychologically ready to be a mediator; or
- the mediator is unable to ensure consistency. For example, the mediator is too disorganized or marginally functional, or others in the environment fail to support the mediator's programming.

Discussion with respondents suggested that there is a growing realization that mediators experiencing the above circumstances must have their own needs met in order to free up sufficient internal resources to mediate. Programs reported handling such situations by:

- diverting the potential mediator into counselling before attempting to begin training the person in learning principles and their application;
- provision of joint counselling and training in behaviour management; or
- provision of some respite to provide a breathing spell, e.g. through direct service delivery to get the client's behaviour under control, or by assisting the person to obtain day programming or short-term residential care for the client.

Provision of counselling was reported to be particularly important in the situation of a child in a stressed family since

the child's negative behaviour may be a reaction to the general tension in the situation. If this is the case, using a pure behaviour modification approach may get one target behaviour under control but another one may then emerge.

A couple of programs reported that they have a full or part-time social worker on staff. Others, because they are under the auspices of an Association, have access to the services of a social worker. However, it appears that in some programs the behaviour therapists are attempting family and/or marital counselling even though they are neither trained nor supervised in this. Part of the rationale for frontline staff moving into this activity is concern that referring the family to another agency will result in increasing the number of people intruding on it and may be perceived as passing the buck. Eight programs identifed a specific need for frontline training in family assessment and therapy. Other programs expressed the desire for regular consultation from someone with training and experience in this type of work.

Mediators who are totally disorganized or marginally functional are perceived to be requiring assistance in developing routines and establishing structure in their lives. However, respondents noted that what may look like disorganization might actually be resistance. It is important to determine which is the case and to take appropriate action. If the situation appears to be one of "resistance", some respondents suggested that it is necessary to confront the mediator and either work through the resistance or else terminate involvement.

Situations where there is inconsistency are perceived likely to result in failure. Sometimes lack of support for the mediator's programming by others in the environment may result from hostility. For example, a sibling who is jealous of the attention the client receives may provoke the individual with behavioural exceptionalities or manipulate the situation to prevent consistent consequencing by the mediator. Again, this may be a situation where counselling would be useful.

Even in situations where the mediator is psychologically ready, and there is consistency in the environment, there appears to be a growing conviction that teaching strategies by rote and targetting isolated behaviours is not sufficient. Several respondents stressed that the real aim should be to develop in the mediator a range of skills, such as observation, problem identification, problem solving (program development) and effective communication. These skills will enable the mediator to understand and respond to the dynamics of the environment. As a result some programs are beginning to focus more on the development of general parenting skills than they used to.

The viewpoint that not all situations benefit from the learning theory approach, and that the intervention provided should depend on the needs of the particular people involved, has support in the professional literature. Garner (1976) discussed the need to

combine behaviour therapy approaches with counselling since he perceived that neither is sufficient in and of itself. Freeman & Thompson (1973) reported positive results from a combined approach which involved teaching mothers behaviour management techniques and also helping them to examine their own feelings and expectations in relationship to the handicapped child. Tymchuk (1975) devised a comprehensive model of intervention which included parental counselling, instruction in behavioural principles and didactic information about mental retardation. However, his report did not include an evaluation of the effectiveness of this approach.

Mediator data collection

Having the mediator produce accurate data, on a regular basis, is important to most programs since this is used to monitor client progress. A couple of respondents suggested that data collection can be a useful motivator for mediators since it enables them to identify small gains which they might not otherwise notice.

Most respondents indicated that, with experience, they had modified their expectations about what was realistic to expect a mediator to collect. Instead they tailor their demands to what they believe the person can do and compromise between what they would like and what is feasible. One person noted that data collection may make the agency look good but it is self-defeating if it exhausts the mediator. Other respondents suggested that unrealistic demands for data collection may cause the mediator to "fudge". This is a no-win situation. The mediator feels guilty, so is under stress, and the data is unreliable.

Three people commented that, in their experience, mediator generated data tends to drop sharply in both volume and quality after an initial period. Therefore, it always has to be supplemented by staff observation. Others suggested that there is no correlation between the mediator's ability to collect data and their ability to implement a program. These respondents reported that they do not feel that poor or no data collection is sufficient reason to terminate service. However, this relaxed view about mediator generated data is not shared by all programs. A few people indicated that they view failure to produce data as indicating that the mediator is not implementing the program and therefore is disinterested.

Mediators who work for other organizations

The main mediators for many children are their parents, although there are a few occasions where teachers are used. With adults, however, the mediator is often a staff person who works for another organization. While the use of any mediator is perceived as requiring tact, sensitivity to the other's "turf", and willingness to be flexible, these are essential when using staff

who work for another agency. Use of a staff person who is not part of the program was reported by respondents as requiring considerations such as:

- the staff mediator is more likely than a parent to perceive himself an expert and/or to think that, as a professional, he should be able to cope. As a result, he may perceive his self-esteem to be at stake;

- the therapist may have been invited in by the staff mediator's supervisor who may have not obtained the staff person's support. This is a tailor-made situation for non-compliance or lack of commitment; and

- sensitivity to the fact the potential mediator is already working full-time and may view imposition of the mediator responsibility as additional work that is not part of his job.

Use of residence staff may be complicated by:

- rotating shifts; and

- high staff turnover.

Staff rotation increases the difficulty of obtaining consistency and the program, as a result, may take longer to show effects. Also, it was suggested that rotating shifts may require the therapist to teach the residence workers individually since it may not be possible to have all staff members present at the same time. However, one person, on a positive note, pointed out that the shift model provides a built-in generalization factor and may facilitate maintenance of the new behaviour since the client is taught to respond appropriately to several people.

High staff turnover in residences requires the behaviour therapist to reassess the situation every time someone is replaced. A change in workers may have a significant impact on the client's behaviour. It is also likely that each new worker will have to be trained.

Although special considerations are necessary for mediators who work for another organization respondents still feel that the mediator model is preferable to direct service. It puts control and ownership of the issue in the hands of the worker, whereas provision of direct service may result in abdication of responsibility. The mediator model also assists staff members in other agencies to feel competent and therefore more positive about their work situation and the client.

Several people provided ideas on how behaviour training programs can most effectively use staff employed by other organizations as mediators. The first requirement is public relations. It was reported to be very necessary to meet with senior people in the

other organizations to explain the service. This assists them to understand what the therapist is doing and lessens the possibility that it will be perceived as a challenge to their authority.

However, respondents indicated that it is equally essential to establish good rapport with the frontline workers. This is seen as requiring the behaviour therapist to be sensitive to the fact he is on someone else's territory and to be careful not to appear to be taking over. Other agencies, like families, should be recognized as systems with their own patterns of interaction and their own dynamics. If the therapist wants to reduce the likelihood that the system will close ranks against the "invader" he must involve the agency staff in defining and designing the program, as well as its implementation. This may require working on a problem which agency staff identify as important, even when the behaviour therapist feels something else is more crucial. Similarly, the therapist must be prepared to substitute a suggested approach with another one if the agency staff are uncomfortable with it.

A couple of respondents suggested that some of the sensitivity that another organization's workers may have about having to ask for assistance may be diffused by reassurance that they are the experts in terms of knowledge about the client.

Some people noted that it is unwise to go into another organization and be completely task oriented. It is important for the staff to perceive that they are viewed as individuals and not simply tools for the behaviour therapist to use. One program tries to convey this message by periodically offering stress management workshops for residence staff. Not only does the director of the program view this as good public relations, she believes that it results in better mediators. Her theory is that workers under stress cannot operate as effectively as they would otherwise.

Responses were mixed regarding the usefulness of providing general workshops in learning theory principles and their applications for staff in other organizations. Several respondents noted that there is often high turnover in residences. Therefore, it may be more cost/effective to only train residence staff when they are to be involved with a specific client. Other people, however, expressed the opinion that the time and effort put into presenting general workshops to other agenices is worthwhile. Such workshops may result in:

- better issue identification because informed staff people collect baseline data prior to referral of the client to the behaviour training service;

- earlier referral of a client before the situation is out of hand and the staff burned-out. Early referral, before the behaviour is entrenched, increases the likelihood of success;

- reduced referrals because some staff people in other agencies learn enough to be able to handle some situations with little or no consultation from the behaviour training service; and

- better performance by staff in other organizations since they have some basic knowledge to build on.

It is worthwhile for behaviour training programs to seriously consider whether or not to conduct general workshops for the staff of other organizations, or to only train people working in other agencies when they are to be mediators for a specific client. Factors relevant to this issue may include staff size in the behaviour training program and staff turnover in other agencies.

Developmentally handicapped parents as mediators

Nine respondents stated that they had had some experience with developmentally handicapped mediators. Only one person reported that these people had consistently been unable to mediate. However, he tempered this observation with the comment that in all situations there had been other factors, such as marital problems. The other respondents had all had the following similar experiences:

- the developmentally handicapped person is often very good at implementing a program designed by someone else, since he tends to be very literal in following instructions and very consistent in applying consequences;

- the individual generally never develops the ability to formulate the problem or design a program;

- even developmentally handicapped mediators who are good at implementing programs never seem able to learn to generalize from one situation to another; and

- developmentally handicapped mediators seem to do better with clearly delineated behaviours, such as temper tantrums, than with targets such as subtle non-compliance.

There was concensus that it always takes much longer to implement a program and obtain gains with a mediator who is developmentally handicapped. However, there was also recognition that an increasing number of developmentally handicapped individuals are having children and it is necessary to develop techniques for working with them. Respondents reported that they use approaches such as modelling, followed by role-playing, and that they modify their expectations for data collection. One person, when working with a developmentally handicapped mediator who was illiterate, had her check off each time a behaviour occured under a picture that represented the behaviour. In this fashion the mediator was able to produce behaviour frequency data. Several people noted that when using the mediator model with a developmentally handicapped parent it is necessary to recognise that they will have difficulty generalizing. Therefore, the case may be active, on a periodic basis, for many years.

Language and culture of the family

Only a few people stated that they had used the mediator model with various linguistic groups. One respondent reported success using translated instructional material and a professional interpreter. This person stressed that using a neighbour or relative to translate is not satisfactory. Not only is there danger of inaccuracy, but also the mediator may be less frank with the therapist because of a desire to protect the family's image. Therefore, it is necessary to obtain a paid professional interpreter to ensure that there is an arms-length relationship between the person doing the interpretation and the mediator.

Some respondents indicated that culture may be more significant than language. People who have had experience working with families from various cultures stated that the program will be rejected if it is not adapted to the family's cultural norms. Therefore, before beginning to work with a family from another culture, even in situations where the potential mediator has a reasonable command of English, it is important for the therapist to educate himself about child-rearing practices and the roles of family members in the culture in question.

Experience with specific goals

a) The most successful goals

Programs were asked to list the goals with which they have had the most success and to rank them by degree of success. Ranking appeared to be difficult for several people and was simply not done, even though successful goals were identified. Among programs which did rank goals by degree of success, the most success appears to be obtained with decreasing non-compliance,

followed by decreasing aggression. This is illustrated in Table 20. As noted in an earlier section, these are two of the most frequently addressed goals in all programs. These goals are considered very important since they directly impinge on whether or not the individual will be accepted by the community.

Table 20

MOST SUCCESSFUL GOALS

Goal	Times identified
• decrease in:	
- non-compliance	13
- aggression	10
- temper tantrums	3
- self-injurious behaviour	4
• development of:	
- self-care skills	12
- communication skills	6
- social skills	4
- toilet training	5

Several people indicated that they believed that they had particularly good success with non-compliance and aggression. Success with these goals was attributed to:

- a high level of motivation in mediators; and
- a behaviour that is concrete, easy to observe, easy to define, and therefore amenable to consistent consequencing.

A couple of respondents suggested that success or lack of success depends, to a large extent, on mediator motivation. The type of goal was perceived as less of a factor in determining success. Mediators were reported to be generally highly motivated to implement a program to develop self-care skills. The technology has been developed to break such activities down into steps which have a gradiated level of difficulty. As a result, there is a high probability of observable gains in a short period. This was reported as being rewarding to mediators and providing encouragement to continue the program.

Respondents suggested that toilet training and the development of communication skills also tend to be successful because specific programs have been developed.

b) Least success

There was a greater range and variety of goals reported as being associated with less success. The most frequently reported goals fitting into this category were:

- decrease in stereotyped behaviour (5 programs);
- decrease in self-injury (5 programs);
- decrease in bizarre behaviour (4 programs); and
- decrease in self-stimulation (3 programs).

Stereotyped behaviour and self-stimulation were perceived by some respondents as self-reinforcing. In addition, respondents noted that mediators apparently are often not really concerned about these behaviours. As a result, they may not be motivated to consistently implement a program to decrease them. As one person observed, the client's engagement in either of these activities may actually be reinforcing for the mediator. This may be the only time the client is not demanding attention.

A couple of respondents suggested that self-stimulation and/or stereotyped behaviour may be very functional to the client as a means of reducing tension or countering boredom. Therefore, when developing a program to reduce them, it is necessary to determine what purpose the behaviour serves for the client. Only then can an appropriate intervention be developed.

Self-injurious behaviour is of particular concern to service providers. It is interesting that it is a goal with which some programs report high levels of success while others report the opposite. Respondents who have not been very successful with this goal suggest that while it may be socially reinforced, in some situations the etiology may be neurological. In other cases the mediator cannot use a technique that might work, for example, planned ignoring, because they are too emotionally involved with the client. Self-injurious behaviour is also perceived to be the type of behaviour that is likely to get intermittent reinforcement from others in the environment, such as peers in a workshop or residence.

Establishing a new behaviour management program

Since hindsight often produces valuable insights, all programs were asked to identify what they would advise someone establishing a new program to do and what they would warn them against doing. Table 17 identifies the most common responses in regard to what should be done.

Quite clearly, in retropect, the respondents saw the primary need to be orientation. This should involve not only familiarization of the new program's staff with the existing resources in the community, but also, visiting other behaviour training programs to learn from their experiences. The second priority appears to be the establishment of an infrastructure, for example, policies and guidelines, along with making arrangements for consultation.

A number of people commented on the importance of choosing a compatible sponsor. For example, respondents stated that people in the community tend to assume that the new program will do whatever its sponsor does. It is also important to ensure, if possible, that the sponsor shares similar philosophies of service delivery, for example, a belief in the mediator model.

Table 21

Things to do	Times mentioned
• Visit existing behaviour management programs to obtain general information.	12
• Become familiar with other services in the community in order to determine how your program might complement their service.	9
• Actively seek coordination and cooperation with other services in the community.	9
• Develop policies and procedures before beginning to work with clients.	9
• Try to determine community needs and expectations and develop a service to meet these.	7
• Be clear about roles and responsibilities, not only for your program vis-a-vis other services in the community but also within your own program.	5
• Arrange for adequate levels of consultation.	5
• Choose your sponsor carefully to ensure you share compatible philosophies of service delivery.	5

Table 22 illustrates the most frequent responses to the question about what should be avoided.

Table 22

Things to avoid	Times mentioned
• Concentrating exclusively on the use of learning theory. In some situations this will result in failure because the larger environmental issues were not addressed.	4
• Being too rigid, e.g. about the type or volume of data collection you expect mediators to produce.	4
• Getting involved in cases or activities that are not part of your mandate.	4
• Taking on too many clients too quickly. Give the program time to settle in.	3

The above suggests that respondents' major concerns involved being too rigid in approach and failing to individualize service provision to meet the client's particular situation. There is obviously also some concern about taking on more than the program can handle.

CHAPTER IX - DEVELOPMENTS OF PARTICULAR INTEREST

Introduction

In the course of discussions with program staff across the province the researcher became aware of the following developments which would appear to be of general interest to all programs.

Staffing through the use of paraprofessionals

One program, the Paraprofessional Outreach Program in Toronto, is totally staffed by paraprofessionals who are all parents of developmentally handicapped children. As noted by the program's Director, the staff are able to share first hand knowledge of what it is like to live with a handicapped child and the effect this can have on family interpersonal relationships. In addition, all have been mediators with their own children using the learning theory approach. As a result the staff in this program have high credibility with parents. At present the model is purely parent to parent and does not use teachers or residential staff as mediators.

The program began in 1977 as a two-year demonstration project under the auspices of the Ontario Institute of Studies in Education (OISE). Considerable resources were put into developing training and supervision methods and there is a continuing high investment in training and supervision for staff. For example, before starting work the new staff person is given a ten-day course in learning theory principles and their application. This is supplemented by monthly in-service programs and weekly supervision.

The Director of the program is developing a training manual for paraprofessionals which she hopes to have completed by June, 1984.

The client as his own mediator

On the rationale that rather than manipulating the external environment, it would be more effective to put control in the hands of the client himself, the program at Chedoke has been working with two clients to train them to be their own mediators. An attempt is being made to teach the two individuals to monitor their own behaviour, and its antecedents, and then to talk themselves out of making a negative response. A fair degree of success has apparently been achieved in the office situation, but neither client has learned to generalize to the community.

Two other programs indicated that they have had a few higher functioning adult clients where they have used a combination of learning theory and insight development. Both report that some clients are able to benefit from the latter and, in so doing, begin to exert some self-control. What appears to happen is that the person develops some understanding of his reactions, especially in regard to things that make him angry, and some ability to talk himself out of responding in an unacceptable fashion.

Development of standards and guidelines

Two groups are presently working on the development of standards and guidelines, namely:

- a group of community-based programs, for more information contact Dorothy Griffiths, York Behaviour Management Services;
- a group of institutional-based programs, for more information contact Milt Blake, Oxford Regional Centre.

The former is developing standards and guidelines that will be specifically applicable to programs operating in the community while the latter group is up-dating the Ministry's 1978 standards document.

Peer reveiw system

Several respondents indicated interest in learning from the experience of other programs and expressed concern that Ministry Program Supervisors, although having broad experience in other areas, generally lack familiarity with behaviour management programs. As a result, they can sometimes only provide limited consultation. It would appear to be helpful to programs to be reviewed by peers who would have not only technical knowledge, but also experience with the day-to-day concerns of managing a behaviour management program.

A group of people in the eastern part of the province have developed and begun using a peer review system. Basic information on this is presented in Appendix H, additional information may be obtained from Donna Davidson, Lanark County Language, Behaviour and Infant Development Program.

CHAPTER X - FUTURE DEVELOPMENTS

The final question on the questionnaire asked respondents to indicate what future developments they would like to see in the network of behaviour training programs. Over half the respondents indicated that it would be desirable to have closer liaison with other behaviour training programs for information sharing and the provision of mutual support. Some attempts have been made to develop a support network by the programs in the Ottawa area and also those in the south-west. However, a number of respondents indicated that they have no contact at all with other programs and feel, therefore, that they are operating in total isolation. Some of them asked the researcher for a copy of her program list so that they could begin to initiate contact with other programs near them.

The Ministry hopes that the current paper will be a start in the sharing of program information, including an up-to-date list of the current programs across the province.

The second most commonly identified desirable development was standards and guidelines specific to community-based programs. As indicated in the previous chapter, a group of program staff are working on this.

A similar need, identifed by five programs, was for standardization of staff qualifications, roles and salaries. However, this suggestion appears to run counter to the strong emphasis, by many programs, on flexibility and the development of a service which meets the unique needs of the community in which it is located.

Finally, and certainly not least, several people identified the need to recognise that while the mediator model is ideal in some situations, it cannot always stand alone, nor take the place of other needed services. As noted earlier, on average, programs reported that the mediator model fails in 20 - 25% of cases. As a result, there is a growing belief that, in some situations, the provision of direct service is an appropriate form of intervention.

GLOSSARY

Antecedent:	Any event which precedes a behaviour and provides the occasion for it to occur.
Baseline:	The rate at which a target behaviour occurs prior to initiating a behaviour change program.
Behavioural:	Refers to a body of principles and procedures derived from laboratory experiments in learning.
Client:	For the purposes of this paper a client is defined as an individual who engages in undesirable behaviour that interfers with his functioning or that of others.
Consequence:	Events in the environment that immediately follow a behaviour and determine the probability of that behaviour occuring in the future.
Environment:	All elements, physical, social and personal, taken individually or collectively, that surround or otherwise impinge upon an individual and potentially influence his behaviour.
Extinction:	The discontinuation of the reinforcement of a response.
Generalization:	The ability to transfer knowledge learned in one situation to another situation which is somewhat different.
IPP (Individual Program Plan):	A specific plan developed to change a specific target behaviour.
Mediator:	An individual in the client's natural environment who is trained to implement a behaviour change program.

Modelling:	An educational procedure in which one person demonstrates to another a procedure to be learned.
Operant Conditioning:	The encouragement of desired behaviour through application of consistent consequences.
Overcorrection:	A procedure whereby the individual is required to restore and to more than compensate for the disturbance caused by his behaviour.
Reinforce:	To encourage certain behaviour by the conscious application of consequences that are shown to increase a behaviour.
Restitution:	A punishment procedure whereby the consequences or an undesirable behaviour must be corrected, e.g. cleaning up a mess.
Stereotyped Behaviour:	Repetitious mannerisms, such as flapping the hands, which do not appear to have a specific purpose.
Target Behaviour:	The behaviour which is to be changed.
Time-out:	Removal from access to reinforcement for a period of time. Often this is removal from social reinforcement, e.g. sending a child to sit alone in a room, provided that this consequence does not reinforce the undesirable behaviour.

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APPENDICES

BEHAVIOUR TRAINING PROGRAM
DESCRIPTION

Appendix A

Purpose

A Behaviour Training Program is designed to assist developmentally handicapped persons of two years of age and above overcome behavioural deficits or problems.

Definition

Behaviour Training is defined as the systematic application of principles of applied behaviour analysis as derived from learning principles generally and operant conditioning procedures specifically. The procedures which may be used include: positive (and negative) reinforcement, shaping, fading, chaining, prompting, cueing, graduated guidance, positive reinforcement, contingent observation, punishment, and aversive conditioning. These procedures would be employed in order to overcome behavioural deficits or problems. Some examples of such behavioural problems or deficits might include head banging, feeding and sleeping habits, muscular co-ordination, toilet training, self-help skills, etc. These procedures attempt to decrease inappropriate behaviour and increase appropriate behaviour. Elements of the above are also found in "Task Analysis" and "Precision Teaching" and for the purpose of this description are considered part of Behaviour Training.

Program Components

This program utilizes a mediator model. The following components are considered to be essential elements for the development and operation of a Behaviour Training Program.

(a) Assessment

A mechanism should be established in order to assess and evaluate the client's and mediator's performance and determine the suitability of the program to meet their needs.

In addition, before a Behaviour Training Program is implemented, a medical examination is necessary in order to eliminate possible medical problems.

(b) Individual Training/Treatment Plan (I.T.P.)

A prescriptive behavioural program as reflected in the I.T.P. should be developed for every client. Prescriptive behavioural programs (I.T.P.'s) should be individually designed to meet the specific needs (behavioural deficits or behaviour problems) of the client. This I.T.P. must be developed in the context of the client's overall Individual Program Plan with due consideration to the nature of the client's natural environment I.T.P.'s should ultimately aim to bring behavioural changes under control of naturally occurring contingencies in the client's environment. All I.T.P.'s are to be approved by a registered psychologist.

All I.T.P.'s should have time-dated objectives. A mechanism should be established to ensure that these objectives are reviewed systematically. This allows the client's performance to be evaluated on a regular ongoing basis.

(c) Mediator Training Plan (M.T.P.)

The Behaviour Therapist trains the mediator in the theory and application of behaviour training procedures and consults with him as he works with the client.

The training program and plan should be designed to fit the individual needs and capabilities of the mediator. It should equip the mediator with the necessary skills to effect behaviour change, maintain behavioural gains and effectively handle new problems situation of the client. Objectives should be time-dated and evaluated.

Behaviour Training Program Procedures

Within the Behaviour Training Program, the following program requirements are to be observed:

(a) Behaviour deficits as well as overt problem behaviours may be targetted for change. It is suggested that for every problem behaviour which is targetted for deceleration at least one positive behaviour be targetted for acceleration.

(b) Unless a clear danger to the client or those around him can be demonstrated as a result of a problem behaviour (e.g. agression), positive programming strategies should be exhausted before alternate methods of decreasing behaviour are tried. In addition, the use of any procedures for the purpose of decreasing a behaviour should be accompanied by positive programming designed to supplement and increase appropriate behaviour.

(c) Before the following procedures (designed to decrease behaviour) may be used, written permission from the parent/legal guardian, and the program director must be given: time-out from positive reinforcement, limited access to meals, or aversive conditioning.

In addition, the following program aspects may also be included:

(a) The development of innovative programming and mediator training methods and materials may be undertaken.

(b) The provision of training in behaviour training principles and procedures to community agents may be offered.

(c) The development of programs to provide public education regarding behaviour training principles.

(d) The provision of parent (mediator) education on topics related to programming and/or behaviour training strategies.

Documentation

Every Individual Program Plan must be accompanied by a systematic method of data collection. The client's file should adequately reflect the client's program and progress within the program.

Location

Behavioural training and programming should be conducted in a familiar, normal environment whenever possible, such as the client's home, school, etc.

Sometimes, however, it may be advantageous to use an in-centre facility to initiate programming or training. In this case, the client may become a temporary in-patient or may be seen on an out-patient basis within the facility. In other cases, the participation of the mediator should still be an integral part of the service.

In cases where consultation is all that is required, it may occur in the school, home or any other appropriate environment.

Staffing

It is suggested that front line staff carry a caseload of 7-9 active cases and that a program director carry ¼ to ½ as many cases as front line staff. However, the case load is dependent on the amount of time that is necessary to spend with the client. Therefore, in some instances, a much greater number could be carried.

In addition, front line staff should be available for consultation services, in situations where training and programming are not required.

The program must have access to a registered psychologist for supervisory and consultation service.

Program Evaluation

A mechanism for evaluating the effectiveness of your program should be developed. This may be accomplished in a variety of ways (e.g. establishing an advisory committee of community resource people, a systematic review of statistical data, etc.)

In addition, a periodic program review and evaluation will be conducted as and when the Ministry deems necessary.

Requirements for Funding

Any non-profit incorporated body may apply for funding of a Behaviour Training Program. If you have identified an adequate number of clients who need a Behaviour Training Program, you should contact the Mental Retardation Co-ordinator in your district. He/She will assist you in the preparation of your proposal. The proposal must then be submitted to the District Working Group who will review your proposal in the light of the Community Needs Analysis and District Plan.

Appendix B

RESPONDENTS

Program name and address	Respondent
• Behaviour Management Service, Algoma District Mental Retardation Services, 205 McNabb Street, Sault Ste. Marie, P6B 1R3. (705) 254-6487	• Donna Kidd
• Behaviour Management Program, Brantford Family Service Bureau, 35 Wellington Street, P.O. Box 381, Brantford, N3T 5N3. (519) 753-4173	• Denise Dolff
• Home Behaviour Training Program, C.P.R.I., P.O. Box 2460, London, N6A 4G6. (519) 471-2540	• Jack Albin
• Behaviour Management Services, Cambridge District AMR, 10 George Street North, Cambridge, N1S 2N2. (519) 621-4310	• Bonny Brecht
• Child Development Program, Confederation College, 1204 Roland Street, Thunder Bay, P7B 5M4. (807) 623-5336	• Cathy Pineau

**

- Adult Behavioural Consultation Service,
  Child and Family Centre,
  Chedoke-McMaster Hospital,
  P.O. Box 200,
  Hamilton, L8N 8Z5.

  (416) 388-0240, ext. 538

  - John Davis

**

- Durham Preschool Behavioural Program,
  Social Services Department,
  Regional Municipality of Durham,
  50 McMillan Drive,
  Oshawa, L1G 3Z5.

  (416) 579-0622

  - Brian Brittain

- Paraprofessional Outreach Program,
  Family Service Association of
  Metropolitan Toronto,
  14 College Street, 4th floor,
  Toronto M5G 1K2.

  (416) 925-2471

  - Mary Perry

- Behaviour Management Program,
  Health Department,
  Regional Municipality of Halton,
  P.O. Box 7000,
  1151 Bronte Road,
  Oakville, L6J 6E1.

  (416) 827-2151, ext. 266

  - Phyllis Washburn
    (Assistant
    Director of
    Community Health)
  - Janice Rotsma

- Behaviour Management Services,
  Kenora-Keewatin AMR,
  225 Main Street South,
  Kenora, P9N 1T3.

  (807) 463-3161

  - Murray Brown
    (Director)
  - Dixie Platt

**

- Lanark-Carlton Place Language,
  Behaviour and Infant Development
  Program,
  267 Edmund Street,
  Carlton Place, K7C 3E8.

  (613) 257-7121

  - Donna Davidson
    (Coordinator)
  - Soryl Markowitz

**

- Metropolitan Toronto AMR,
  100 Sunrise Avenue,
  Toronto, M4A 1B3.

  (416) 752-5311

  - Anna Miransky (Ass't Director Children's Services)
  - Stephanie Listowel

**

- Behaviour Training Services,
  Mississauga Hospital,
  100 Queensway Street West,
  Mississauga, L5B 1B8.

  (416) 279-7330, ext. 2400

  - Leanne Baldwin

**

- Niagara Region Behaviour Management Program,
  125 Dieppe Road,
  St. Catherines, L2M 6RT.

  (416) 688-5222

  - Fran Owen (Coordinator)
  - Mary Draper
  - Nancy Johnson (Psychologist)

**

- Community Behaviour Management Services,
  Ongwanada Hospital,
  797 Princess Street,
  Kingston, K7L 1G1.

  (613) 548-4417, ext. 68

  - Joy Mills
  - Noel Derrick (Psychologist)

- Ottawa-Carlton Behaviour Management Program,
  Ottawa-Carlton CAS,
  1370 Bank Street,
  Ottawa, K1H 7Y3.

  (613) 737-1643

  - Sharon Harris

- Behaviour Training Program,
  Owen Sound and District AMR,
  830 Third Avenue East,
  Owen Sound, N4K 2K5.

  (519) 371-9251

  - Marilyn Thompson (Director of Children's Services)
  - Mike O'Brien

- Developmental Services of Prescott-Russell,
  Prescott-Russell AMR,
  102 Main Street,
  Hawkesbury, K6A 2R2.

  (613) 632-0101

- Jacques LaBelle

- Behaviour Management Program,
  Sudbury and District AMR,
  245 Mountain Street,
  Sudbury, P3B 2T8.

  (705) 674-1451

- Alex Carter

**

- Behaviour Management Program,
  Surrey Place Centre,
  2 Surrey Place,
  Toronto, M5S 2C2.

  (416) 925-5141

- Clay Moore

- Developmental and Behavioural Services,
  (Children's Program),
  Trent University,
  Peterborough, K9J 7B8.

  (705) 748-1402

- Vance Lasenby

- Behaviour Training Services,
  (Adolescent and Adult Program),
  Trent University,
  Peterborough, K9J 7B8

  (705) 748-1402

- Gerry Fucile

- Behaviour Training Program,
  Walkerton DAMR,
  Box 1059,
  Walkerton, N0G 2V0.

  (519) 881-0411

- Patricia Ross

**

- Children's and Infant's Development Services,
  Regional Municipality of York,
  Day Care Services,
  134 Main Street South,
  Newmarket, L3Y 3Y7.

  (416) 881-2524

  - Doreen Gordon (Director of Day Care)
  - Sue Mosten

**

- Behaviour Management Services,
  York Central Hospital,
  10 Trench Street,
  Richmond Hill, L4C 4Z3.

  (416) 884-5819

  - Dorothy Griffiths

** on-site interview.

BEHAVIOR MANAGEMENT PROGRAMS QUESTIONNAIRE

A. GENERAL BACKGROUND INFORMATION

Name of Program_____

Name of respondent_____

1) Date when your program began _____

2) Sponsoring organization

a) when program began _____

b) now, if different _____

c) please identify the advantages of being sponsored by this particular type of organization

d) please identify the disadvantages of sponsored by this particular type of organization

4) Do you receive funds from any source other than the Ministry of Community and Social Services?

Yes_____ No_____

If yes, from what source?

How much?_____

B PROGRAM MANDATE

1) What are the objectives of your service?

2) What is your catchment area?

3) What other services are there in your catchment area for the same type of clients that you serve?

4) What services are you currently asked to provide which you do not feel are part of your mandate? For whom?

5) Why do you feel referral sources ask you to provide these services?

C ADMISSION/DISCHARGE PROCEDURES

1) What criteria do you use to decide if a client is eligible for service?

2) Do you have any behavioral exclusions?

3) Please describe your intake and selection procedure

If you have a written intake and selection procedure may we have a copy?

4) How do you determine when a case should be terminated?

If you have a written procedure may we have a copy?

5) During the past 12 month period:

- o how many cases were readmissions to your program?____
- o how many cases dropped out?_____

6) What seem to be the major reasons for dropping-out?

7) Does your program have a waiting list?

Yes____ No_____

If yes, what is the current size of the waiting list?_____

What is the average waiting time on the waiting list?_____

D CLIENT CHARACTERISTICS

1) In your current caseload how many clients:

- o have a psychometrically confirmed diagnosis of developmental handicap?_____
- o do not have a psychometrically confirmed diagnosis of developmental handicap?_____

E SERVICE DELIVERY

1) In your current caseload how many clients are receiving each of the following modes of service? (In some cases a client may be receiving service through more than one modality, please count each modality separately)

- o joint programming with the mediator and the client in the centre ___
- o joint programming with the mediator and the client in his home, school or place of work ___
- o individual programming for the client only in the centre ___
- o individual programming for the client only in his home, school or place of employment ___
- o training with the mediator only ___
- o group programming for clients only ___
- o group programming for mediators only ___
- o other, please specify_____ ___

_____

2) How are the various modes coordinated or integrated?

3) Please indicate the number of current clients receiving visits over the past six months at the following levels of frequency. Please separate out by children and adults with child defined as a person under the age of 18.

	child	adult
o once every 1 - 2 weeks	___	___
o once every 3 - 4 weeks	___	___
o once every 1 - 2 months	___	___
o less frequently	___	___

6

4) In your current caseload what number of clients, separated out into adults and children (persons under age 18), are receiving visits in:

	child	adult
o own home	____	____
o client's other setting, e.g. workshop, group home	____	____

5) What types of client's other settings do your staff visit?

6) For the cases closed in the past twelve month period please estimate the number which received service for each of the following time durations:

o 1 - 3 months____ o 1 - 2 years____

o 4 - 6 months____ o over 2 years____

o 7 - 11 months____

7) In your current caseload how many clients have the following goals? Please separate out by children and adults. Child should be defined as a person under age 18.

goal	child	adult
o development of communication skills	____	____
o development of self-care skills	____	____
o development of community living skills, e.g. using public transport	____	____
o decrease in		
- self injurious behavior	____	____
- aggression	____	____
- hyperactivity	____	____
- non-compliance	____	____
- bizarre or stereotyped behaviors	____	____
o other, please specify	____	____

8) What standard training packages or curriculum (e.g. Vulpe), if any, do you use?

name of package	% of clients used with
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9) To what extent do you use your own "home grown" training packages or curricula? _____%

10) What methods do you use to monitor progress while the client is still in the program?

11) Which of these methods do you find provides you with the most useful information for adjusting goals or approach if this appears necessary?

12) Once a client is discharged how is follow-up done?

13) What approaches, if any, have you used in the past which did not work or you were not satisfied with? What were the main problems with them?

14) What goals (e.g. those listed in question 7 of this section) do you believe that your program has the most success with? Please list and indicate degree of success using #1 for the most success and so on.

goal	degree of success
_____	_____
_____	_____
_____	_____
_____	_____

15) Why do you think that your program has the most success with the above types of goals?

16) What types of goals does your program have the least success with? Please rank in order using #1 to signify least success.

goal	degree of lack of success
_____	_____
_____	_____
_____	_____

17) Why do you think that your program has least success with these types of goals?

18) What do you view as the strengths of the mediator model?

19) Have you had situations where the mediator model was tried but failed?

Yes_____ No_____

If yes, please identify the types of situations

How frequent are such situations?

20) How have you handled situations in which the mediator model failed?

21) What gaps in service do you find for clients who have (or are being) discharged from your program?

22) Are you aware of any groups of clients in the community who should or could be using your service but are not?

Yes_____ No_____

Don't know_____

If yes, what type of group?

If yes, why do you think they are not using your service?

F STAFFING

1) Does the Director of the Program carry a caseload?

Yes___ No_____

If yes, how many clients?_____

2)What do you look for when hiring paid staff? (e.g. qualifications, experience, personality characteristics)

3) Does your program use volunteers? Yes____, No_____

If no, why not?

If yes, how many do you have currently?_____

If yes, what sort of activities do you use them for?

4) What percentage of paid staff time is devoted to the following

activity	% of time
o visits to mediator/client in:	
- family home	_____
- client's other settings, e.g. workshop, school	_____
o assessment	_____
o case planning and review (IPP), report writing/record keeping	_____
o staff supervision & training	_____
o consultation to and staff training in other agencies	_____
o general community eduction (e.g. public presentations)	_____
o travel	_____

5) Does your program have a full-time or regularly consulting registered psychologist?

Yes_____ No_____

If yes, does he/she review all IPPs? _____

If the program does not have the services of a registered psychologist, why not?

6) Do you feel it is necessary to have a registered psychologist review all IPPs?

Yes_____ No_____

7) Do you have any staff training needs? Yes____, No_____

If yes, please identify

8) In the last two years what has been the staff turnover experience in your agency?

- o none left _____
- o 1 - 2 left _____
- o 3 -4 left _____
- o 5 or more left____

G PROGRAM EVALUATION

1) What indicators of over-all program effectiveness does your agency use?

2) Which do you find most useful in providing the agency with guidance in regard to overall program effectiveness?

3)Please indicate what measures of program efficiency your service uses and rank for degree of usefulness in determining efficiency. Use 1 = most useful.

method	degree of usefulness
_____	____
_____	____
_____	____
_____	____

IF THERE IS ANY ANALYZED PROGRAM DATA AVAILABLE MAY WE HAVE A COPY?

4) Which of the following types of documentation does your program try to collect on each case? Please indicate the % of files where, if you did a file audit, you would expect to find the documentation present and up-to-date. If you do not collect a particular type of data please indicate by N/A.

data type	% present and complete
o referral form	_____
o medical report	_____
o assessment report	_____
o family history	_____
o individual treatment plan	_____
o mediator training plan	_____
o progress notes	_____
o termination summary	_____
o formal follow-up data	_____
o other, please specify	
_____	_____
_____	_____

On what basis did you make your estimation of what would or would not be in the files? (e.g. we have just done a file audit)

H COMMUNITY RELATIONSHIPS

1) What type of coordination is there between your program and other agencies in the community. Please indicate specifically type of other agency with which you are involved and how.

2) Do you find your staff picking up the role of case manager or advocate for clients?

Yes_____ No_____

If yes, why do you think this role falls to your agency?

I PROGRAM STRENGTHS AND CONCERNS

1) What do you view as the major strengths of your program? Please rank order your response indicating by #1 the greatest stength.

strength	rank
_____	1
_____	2
_____	3
_____	4
_____	5

2) What are the key ingredients which contributed to the development of these strengths?

3) What are your major areas of concern about your program? Please rank with # 1 indicating the area of greatest concern.

concern	rank
_____	1
_____	2
_____	3
_____	4

4) What ingredients do you believe are responsible for these concerns?

5) If someone just developing a new behavior management program came to you for advice what would you urge them to do and urge them not to do?

a) I would urge the person to

b) I would warn the person about

5) What future developments would you like to see in the network of behavior management programs across the province. In other words what do you feel would make them even better than they are now? Please indicate on a separate sheet of paper.

THANKYOU FOR YOUR ASSISTANCE

BEHAVIOUR MANAGEMENT PROGRAMME

Appendix D

MEDICAL INFORMATION

CLIENT: _____ DATE OF BIRTH _____

ADDRESS: _____

Reason for referral to the _____ Behaviour Management Programme.

_____

_____

_____

General Nature of Proposed Behaviour Management Intervention

_____

_____

_____

1) GENERAL STATE OF HEALTH:

2) MEDICAL ANOMOLIES

3) MEDICATIONS PRESENTLY PRESCRIBED: (Type, dosage, purpose.)

4) ARE YOU AWARE OF ANY MEDICAL CONDITION IN THIS PATIENT THAT WOULD CONTRIBUTE TO HIS/HER ABOVE DESCRIBED BEHAVIOUR PROBLEM?

5) ARE THERE ANY MEDICAL LIMITATIONS TO PROGRAMMING IN THIS AREA OF DEVELOPMENT?

6) WOULD YOU LIKE TO BE KEPT INFORMED ABOUT THIS PATIENT'S PROGRESS DURING OUR CONSULTATION?

I, the undersigned, certify that I have examined the above named patient and agree that there is no medical reason why he/she is unable to receive programming in the described area.

_____ Physician's signature _____ Date

Appendix E

BEHAVIOUR MANAGEMENT PROGRAM SURVEY

1. How did you find out about the Program? _____

_____

_____

2. Who referred your child to the Program? _____

_____

3. What type of service were you expecting when your child was referred? _____

_____

4. Are you aware of any other agency that offers the same service, if so, who? _____

_____

5. Are you satisfied with the number of times a staff person visited?

Yes ☐ No ☐

If no, would you like:

More Visits ☐ Less Visits ☐

6. How often would you like a staff person to visit?

☐ Once a week

☐ Once every two weeks

☐ Once a month

☐ Less than once a month

7. Please circle one number for each of the following questions:
1 - Not at all
2 - A little
3 - Moderately
4 - quite a lot
5 - extremely

(a) Were the staff friendly? 1 2 3 4 5

(b) Did they seem knowledgeable about Behaviour Management? 1 2 3 4 5

(c) Were they concerned or interested about your child? 1 2 3 4 5

(d) Were they helpful in providing you with ideas about your child? 1 2 3 4 5

8. In what area did the Behaviour Management staff help you the most? e.g., direct work with child, training materials and exercises, consultations with parent, books and articles loaned, etc.

_____

_____

_____

9. Did the child's behaviour improve in the area of concern?

☐ Yes

☐ A little

☐ No

10. Did the staff explain the principles involved in changing a child's behaviour to your satisfaction?

☐ Yes

☐ A little

☐ No

11. Do you feel more confident in understanding causes of your child's behaviour and ways to change it?

☐ Yes

☐ A little

☐ No

12. Were staff available for crisis situations or when you felt you needed to speak to them immediately?

Yes ☐ No ☐

13. Was your decision to refer the child affected by the fact that the Behaviour Management Program is sponsored by the local Association for the Mentally Retarded?

☐ Yes

☐ A little bit

☐ No

14. Have you told or spoken to anyone about this service?

Yes ☐ No ☐

15. Would you recommend this program to someone else?

Yes ☐ No ☐

Do you have any other comments about the program. What could we do to improve the service, etc.?

_____

_____

_____

_____

BEHAVIOUR TRAINING SERVICES

TIME UTILIZATION - DEFINITIONS

Direct Client Contact:	Defined as face to face contact with mediator(s) and/or client. This would include direct observation.
Indirect Client Contact:	This includes such things as phone calls, attendance at case conferences, meetings with family support workers, case managers, adult protective service workers.
Case Documentation:	Time spend designing programmes, updating files, summaries, contact notes.
Workshop a) Preparation:	Time spent collecting, organizing, rehearsing materials.
b) Presentation:	Actual time involved in presentation from beginning to end. Indicate type of workshop.
Agency/Community/Liason:	This would include committee meetings, public relations, orientation presentations. It would exclude meetings with other agencies to discuss specific clients.
Case Supervision:	Time spent formally or informally with co-ordinator discussing specific clients and job performance.
Behaviour Training Services Programme Development:	This would be defined as time spent in staff meetings, b) preparing materials for improved delivery of services i.e. parent package on 1 to 1 mediator training.
Staff Development:	Time spent attending conferences, visiting neighbouring programmes, attending lectures.
Travel Time:	Time spent travelling back and forth from home visits, meetings etc.
Overtime hours worked:	Taken back balance - self-explanatory.

At the end of each month calculate the percentage of time spent in each category.

NAME:_____

MONTH:_____

TIME UTILIZATION SHEET

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Tot	%
Direct Client Contact																																	
Indirect Client Contact																																	
Case Documentation																																	
Workshop- Prep. **Presentation**																																	
Agency/Community/ Liason																																	
Case Supervision																																	
B.T.S. Programme Development																																	
Staff Development																																	
Travel Time																																	
TOTAL																																	
Overtime Hours Worked																																	
Overtime Hours Taken Back																																	
BALANCE																																	

Appendix G

GUIDELINES FOR PEER REVIEW

I) PREAMBLE

Any review should be a positive and constructive process and its major emphasis should be to assist in the development of various programs as well as to review the program. Therefore, it is understood that a major emphasis of any Peer Review should be a consultation with regards to sharing of relevant information concerning program functioning.

Any structure for review, in and of itself, cannot insure a positive and constructive process. It is the people involved and their attitude, caring, and commitment which will be the determining factor. Therefore, it is essential that there be much communication concerning the process and also that all programs and staff of Community Based Programs make a commitment to insure that the process be positive and constructive.

It cannot be overemphasized that the success of Peer Review relates to the process and not to this document. Therefore, the words "Guidelines for Peer Review" were used instead of "Manual for Peer Review". This is to underline the fact of the flexibility as well as the on-going development of these Guidelines. The Guidelines are not "written in stone" and will be continually developed to reflect the feedback from future Peer Reviews. The forms provided are meant to be a Guideline and will be changed according to the nature of the program reviewed as well as by the decision of Peer Review members.

1) Goal

The goal is to provide positive review for the community special support programs in the Eastern Ontario region.

2) Objectives

The objectives of this process are as follows:

i) Consultation: -The spirit should be one of co-operation and of sharing of information between the review team and the program being reviewed so that the end result of the process would be of assistance in developing effective community based programs. It is expected that much learning by both reviewers and reviewees can occur during this process . This would not only be in the area of the process of the review, but also (and perhaps more important) in the area of what is constructive about various programs.

ii) The review process should point out the good points of any program reviewed. This, of course, would require a positive attitude, as discussed earlier

iii) To create good communication amongst programs, particularly around area of common concerns. The review team should request and initiate discussions to determine what the concerns are, whether with regards to program structure, liaison with the community, liaison with the Ministry, etc., of the program being reviewed. The program reviewed should understand that it can request the help of the review team in attempting to define these concerns.

iv) To determine whether the program reviewed is meeting its own defined objectives, using whatever measures the program has already established to determine this.

v) To measure the effectiveness of the program with regard to constructive client/mediator change. This may include a number of measures of effectiveness and should be flexible, depending on the nature of the program being reviewed. It should rely heavily on the methods of measurement that the program being reviewed uses. This should include:

a) Perusal of relevant data
b) Parental feedback
c) Feedback from other community agencies
d) Self-evaluation.

vi) To make positive and constructive recommendations with regard to any perceived weaknesses. Once again, this should be in the spirit of assisting constructive developmental change.

II) PROGRAM COMPONENTS

Any community program should possess to a greater or lesser extent a number of major components. Obviously, there must be great flexibility in how these components would be established in these programs. The components are as follows:

1) Overall Mandate -- A clearly specified mandate that outlines what its service is and who it will offer it to. Within the mandate, a statement of the methodology that the program uses, ie., how that program serves the community, what model of intervention it uses, understandable and realistic goals and objectives which the program is attempting to meet.

2) Service Delivery

a) Process: The process of handling an individual client from first contact to termination should be clearly specified and understood by all members of the program. This would seem to necessitate the existence of a policy and procedures manual.

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b) Documentation: While allowing for flexibility and for individual development of appropriate forms, etc., we suggest that the following documentation be kept:

i) Client Files

The forms and information mentioned below should be contained in the client files if appropriate to the given program:

- referral form
- social history form
- permission for release of information and to obtain information
- medical report
- correspondence record
- assessment data
- mediator's contract
- IPP's (individual program plans)
- ITP's (individual training plans)
- home contact record or therapy lesson plan
- record of other contacts
- conference reports
- mediator's assignment sheet (if applicable)
- on-going data record and charts (if applicable)
- termination record (while fading out and when completed)
- parental evaluation questionnaire.

ii) Agency Data

- breakdown of referrals (number of active, waiting, terminated)
- number of contacts and what kind
- breakdown of staff activity
- quarterly and financial program reports
- any other proposals for expansion, working with other community agencies, etc.

3) Program Functioning

A community based program should commit itself to some form of on-going self-evaluation which would enable it to assess its functioning. The two major areas for this would be:

a) The creation and implementation IPP's and ITP's

Depending on the program being reviewed there should be some form of systematic process through which it designs its intervention strategies. What should be seen in this process are such things as:

i) Appropriate use of all background information
ii) Some kind of initial and on-going assessment
iii) Some constructive methodology used to design programs
iv) Appropriate use of specialized consultation
v) A realistic and constructive implementation schedule.

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b) Method of Measurement

Depending on the type of community program there should be some form of defined method of measurement which is used to measure client/mediator progress.

This would include some form of measurement which relates to the targets that the program has defined. It could also include the opportunity for feedback from mediators, community agencies, etc., concerning the effectiveness of the intervention.

4) Relationships with the Community

Community based programs should endeavour to develop and maintain constructive working relationships with relevant community agencies. This would include some of the following:

a) Good working relationships with community agencies such as district work groups, social, educational and health agencies (hospitals, Children's Aid Societies, etc);

b) Advisory Committee -- it is suggested that all programs draw a number of individuals from its community to serve on an advisory committee.

c) Sponsor -- there should exist a clear delineation of responsibilities concomitant with appropriate communication links within the line between the program and its sponsor. Needless to say, there should be a system of communication which is supportive and helpful;

d) Ministry -- a commitment to supportive reciprocal communication should exist by both program staff and Ministry personnel;

e) Public Information and Education -- programs should inform the community they serve about the nature of the program as well as the needs of the group they are serving. They should also be available to provide public education sessions when requested, as time permits.

5) Team Functioning

a) Staff Training & Development -- Programs should endeavour to determine the training needs of its staff and to make every attempt to provide the relevant training. It would also be helpful if the Ministry would fully recognize the need and commit the appropriate funds.

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b) Team Interaction -- Although there will exist a number of managerial structures within programs, there should exist:

i) a smoothly functioning communication pattern;
ii) use of all the abilities of individual program members, i.e.-gathering of appropriate input for decision making, program design, etc.

III) PEER REVIEW PROCESS

1) Notification -- The program supervisors (Ministry of Community & Social Services) will:

a) decide on the agencies to be reviewed and the dates;

b) contact the agency at least 4 months before the actual review to inform them and to solicit from them names of persons the program would like to have on the review team;

c) respecting their options as much as possible, decide on the membership of the peer review team. The members of the review team should be from the same type of program that is being reviewed but should come from different geographical locations. The review team should have a member(s) from either a program that has been reviewed and/or a member of a past review team;

d) contact the members of the review team at least eight weeks before the review choosing one member to be chairperson.

e) arrange for reimbursement of expenses to the program -- not to come out of program budget.

2) Preparation

a) The co-ordinator of the program being reviewed will provide to the review team at least four weeks before the review the following information:

i) last two quarterly program reports
ii) last annual program report
iii) policy and procedures manual
iv) a document outlining goals and objectives, usually the original proposal (if this information is not already contained in the policy and procedures manual)
v) copies of the latest parent (mediator/consumer) evaluation questionnaire
vi) if existing, written feedback/evaluation concerning any community information/education sessions

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vii) basic staff information -- who, how many, qualifications, roles, responsibilities

viii) brief statement of methods of measurement used to determine whether meeting goals and objectives (if not contained elsewhere) as related to client population and community as a whole

ix) a list of any concerns that the program has with regards to any program component

x) brief description of the relationship with the Ministry -- what and who are the links, is the relationship supportive, helpful, etc. -- What do you need?

xi) a "model" file which contains all documentation that the program uses in appropriate order.

b) The chairperson of the review team will:

i) contact the members of the review team and arrange a ½ to 1-day meeting of all review team members two weeks before the review to: - get to know each other, discuss the roles and responsibilities of each, decide on the schedule and develop appropriate forms to be used during the review. When the review starts, it is understood that the chairperson becomes an equal member of the review team and only has special responsibilities in the sense that he/she will facilitate certain aspects of the review such as keeping on time, etc.

3) On-Site -- When there, the process will be as follows:

a) Informal Social Meeting -- the first step of a review process is to have an informal social meeting of all participants. This is not to de-emphasize the aspect that it is a review but rather to promote the optimum positive attitude.

b) Staff Interview and Examination of Files -- have an interview with all staff to do the following:

i) Choose one file per worker at random and examine it from a structural point of view to establish if the file is in order (organized appropriately, neat, intelligible, if it has all the necessary forms, etc)

ii) Each worker will then choose another one or two (depending on time needed for discussion of the first one) which will be examined in much depth with regards to program functioning and effectiveness, concerns and overall discussion with the review. This discussion would closely resemble a case conference and would allow for more of the consultative and information sharing aspects of peer review.

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iii) An integrated expansion of the interview to explore such areas as:

a) Their interpretation of the philosophy and essence of the program

b) Workers' knowledge and background and what additional expertise would be helpful

c) Team functioning -- Clarity of role, chain of command. Nature of communication amongst all team -- management. Assessment of morale, motivation, etc.

d) Concerns -- any concerns staff members might have.

To facilitate i, ii and iii, a form resembling a combination of Appendixes A and B will be developed by the review team. Although that information is required and a form would be helpful for structure, the reviewers must be careful not to allow the "paper" to interfere with the flow of the interview. It is a guide.

c) Other interviews -- the review team will gather relevant information by interviewing the following:

i) Parents -- on site and in home to ascertain (Appendix C). This will include choosing parents as well as giving the opportunity to any parent who wants to give input to be interviewed.

a) Are you satisfied with the program and the input you are receiving?

b) Have you observed any noticeable changes?

c) Are workers approachable, available, knowledgeable? Have they established a good rapport?

d) Do you understand the goals of the program being received?

e) What has happened to your child/adolescent/adult as a result of your involvement with this program?

f) Recommendations -- any recommendations regarding expansion, more time, the program, etc.

ii) Management -- representative(s) of the Sponsor and the Co-ordinator to ascertain:

a) What is the management style used -- an assessment of the team functioning.

b) Assessment of performance of administrative functions -- filing system, reports, etc.

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c) Description of the process of supervision, how it is done, how often, etc.

d) What is chain of command -- clarity of it, relationship to supervisors, etc.

e) What is the relationship with community agencies -- is it constructive, effective? -- Same questions for relationship to the Ministry and Sponsor.

iii) Consultant(s), (Psychologists, Speech Therapists, etc) -- to ascertain (Appendix D)

a) What is your role -- how clear is it?

b) What are the goals and objectives of the program as you see them?

c) Do you do supervision -- what? -- why?

iv) Community Agencies to ascertain (Appendix E)

a) Is the program accessible, available? Are you generally satisfied?

b) What is the nature of your communication with the program? Is it constructive?

c) Recommendations, suggestions, etc.

d) Assessment meeting

i) the review team meets to discuss its findings and recommendations.
ii) the program reviewed meets to discuss its response to and evaluation of the peer review process.

e) Documentation of Review Process

i) each member of the review team fills out a Pre-Draft Summary (Appendix F)
ii) the program reviewed fills out an evaluation form (Appendix G)

f) Meeting afterwards to discuss review and evaluation of review team

The last afternoon should be set aside so that:

i) the review team discusses its findings and recommendations
ii) the program reviewed gives feedback concerning evaluation of the review team.

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4) After

a) Within three weeks the Chairperson will submit to the Sponsor and/or Co-ordinator of the program reviewed as well as to the other members of the review team a draft report which will, as much as possible, represent a synopsis of all the pre-draft summaries.

b) Upon receipt, the other members of the review team as well as the sponsor and/or co-ordinator of the program reviewed will within three weeks submit a written response to the chairperson concerning the draft report.

c) The chairperson will then incorporate this feedback into a final report which he/she will send to the Program Supervisor within three weeks. He/she will also send the written responses of the other members of the review team as well as the sponsor and/or co-ordinator of the program reviewed. Since all members of a review team are equal, it is understood that any major differences of opinion will stand and that it will be up to the Program Supervisor to handle this in negotiation with the program reviewed.

d) Within ten days after this, the program supervisor after adding his/her comments will send the report to the agency reviewed.

e) Anywhere from 2 - 4 weeks later, after the team being reviewed has had at least a week to peruse the final report, the program supervisor will start a process which will include the following:

i) Assist the agency with developing a plan of action to allow for the implementation of the recommendations made by the peer review team.

ii) Facilitate the necessary consultation so that the agency can work on its plan of action. This may include requesting some members of the review team to continue to work with the program.

iii) Provide, during the whole process -- both during & after -- the needed functions for legal considerations.

5) Contents of the Report

The report to be submitted by the review team will consist of the following:

a) A statement of where the program is at with regards to fulfilling each of the five program components described earlier. It is imperative that the "good" and constructive aspects of the program with regards to these components be stated.

b) A statement of the concerns as expressed by the program.

c) Specific recommendations -- Any recommendations made should be constructive and developmental. It is also essential that in the report that there be a clear differentiation made between statements based on more objective and factual sources of information and those which represent considered opinion. While it is apparent that the review team will be exposed to some subjective variables, it must be careful in making statements based on this type of information. Further, any recommendations made should clearly be of the type that would assist in the development of a more effective service.

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6) Proposed schedule of a peer review -- It must be clearly stated that enough time has to be allocated for a review if it is to be positive, constructive and consultative. A review cannot be too hectic. Therefore the following proposed schedule is offered based on doing a review on a team, consisting of a co-ordinator and three front line workers. Program staff will not necessarily have to be present all the time, but only when needed. The review team would consist of at least three people.

a) Preparation

i) four weeks before the review -- four hours to read the preparation material. All review team members.
ii) two weeks before the review -- four hours for all review team members to accomplish 2b
iii) ½ to one day for the chairperson to consolidate results of ii) above

b) On-site

i) Day One

-Review team members arrive 5p.m. check in, etc.
-6 p.m. - 10 p.m. -- informal dinner/social gathering of all participants.

ii) Day Two

- 9:00 - 2:45 -- Staff interviews and examination of files
-10:30 - 10:50 -- Break
-12:00 - 1:15 -- Break
- 2:45 - 3:00 -- Break
- 3:00 - 5:00 -- Interview Co-ordinator

iii) Day Three

- 9:00 - 10:30 -- Three in-home interviews of parents (as much as possible should be parents whose files were examined).
-10:30 - 10:50 -- Break
-10:50 - 12:00 -- Further parent interviews and/or time for program staff to consult and share information with review team personnel.
-12:00 - 1:15 -- Break
- 1:15 - 2:15 -- Interview District Working Group, Advisory Committee and Sponsor
- 2:15 - 3:15 -- All review team staff interview consultant
- 3:15 - 3:35 -- Break
- 3:35 - 4:35 -- Interview three Community Agencies that the program is involved with.

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- Two hours for:

  i) review team to discuss amongst themselves findings and recommendations
  ii) program staff to discuss evaluation of review team.

iv) Day Four

9:00 - 12:00	-- Review team writes up pre-draft summary; program staff write up evaluation of the process.
10:30 - 10:50	-- Break
12:00 - 1:15	-- Break
1:15 - 2:45	-- Review team discusses its findings and recommendations
2:45 - 3:00	-- Break
3:00 - ?	-- program staff discusses its evaluation of of the process.

7) Evaluation and Development of the Peer Review Process -- after each peer review is done the results of the evaluation will be forwarded to the Committee on Peer Review. The Committee will then use the input to further develop the model for Peer Review. In this sense the model will never become static but will continually grow as each review is done.